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ABSTRACT

A project examined the changing educational needs of community nurses in Britain with regard to needs assessment and quality of care in the context of the National Health Service and Community Care Act 1990. Phase 1 clarified the term "needs assessment" through focus group discussions. Phase 2 used observations and interviews to examine educational preparation and practice of needs assessment by district nurses and health visitors and develop recommendations for future educational provision. In phase 3, a group of experts from interest groups scrutinized findings and proposals for recommendations that were subjected to a content analysis. The ability to assess needs of individuals, families, and the local population served on the community nursing caseload appeared as a holistic endeavor. Certain aspects of needs assessment were learned better than others, perhaps due to a lack of clarity and understanding about some embedded features of need. Professional judgment required the development of critical skills and ability to conceptualize and articulate practice. The important role of the caseload-holding specialist teacher in the practice setting was highlighted. Data suggested real difficulties in teaching in an uncertain and rapidly changing environment in community nursing education and practice. Upgrading the level of preparation for community practice teachers was recommended. (Appendixes include 250 references, discussion group materials, instruments, and data tables.) (YLB)

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AN INVESTIGATION INTO THE CHANGING EDUCATIONAL NEEDS OF COMMUNITY NURSES WITH REGARD TO NEEDS ASSESSMENT AND QUALITY OF CARE IN THE CONTEXT OF THE NHS AND COMMUNITY CARE ACT, 1990

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Report commissioned by the English National Board for Nursing, Midwifery and Health Visiting, London

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Responsibility for the views expressed, issues of interpretation, questions of inclusion and omission, remain always with the Research Team and do not necessarily reflect the views of the English National Board for Nursing, Midwifery and Health Visiting.

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1. INTRODUCTION AND OVERVIEW

BACKGROUND TO THE STUDY

In the summer of 1993, the English National Board for Nursing, Midwifery and Health Visiting (ENB) put out to tender a commission for research to investigate the changing educational needs of community nurses with regard to needs assessment and quality of care in the context of the NHS and Community Care Act 1990. The timing of the call related to two factors which had an important bearing on the proposed research design which was subsequently commissioned by the ENB, to commence in January 1994.

First, the 'Community Care' part of the NHS and Community Care Act 1990 (Department of Health [DoH] 1989a) had not yet been implemented; this was scheduled to begin in October 1993. At the time of planning the study, there were a few pilot projects which had begun to work through the processes of assessing and sharing care between health and social services, but it remained a future challenge for most areas. However, the legislation specifies certain responsibilities which had not formerly been explicit and the idea of the 'internal market' was fully established with a central importance afforded to the role of needs assessment (DoH 1989b).

The amount of actual research into the implementation of the whole Act was still limited in 1993. A decision was made, therefore, not to confine the investigation solely to the role of community nurses in relation to 'community care' as specified under the Act. Instead, it was proposed to consider the changing role of community nurses in relation to needs assessment and quality of care, in the 'new NHS' as whole.

The second important issue for community nurse education concerned the Post-Registration Education and Practice recommendations made by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). The proposals which were current at that time (UKCC 1993) were subsequently replaced by a later report (UKCC 1994), which was significantly changed. However, when the research proposal was being planned, the UKCC was recommending that six, instead of the eventual eight, different community nursing qualifications would be required (community children's nursing was not recognised as a separate area of practice, and practice nurse education was to have been combined with that of district nursing). Also, it was known that a separate ENB commissioned study into the educational needs of mental health and mental handicap nurses was underway (Redfern and Norman 1996); it was presumed it would consider needs assessment for these groups.

Furthermore, the different employment patterns, educational levels, lengths and organisation of programmes of preparation suggested that attempting to encompass all the areas of community nursing practice into a single study would be methodologically very difficult. It was decided to focus on district nurses and health visitors, as curriculum requirements for courses of preparation for these two groups are long established, so a broad comparability from different centres may be expected. This is less true for the other community nursing programmes whose development followed different patterns across the country; the newer community nursing groups are particularly variable. Also, the UKCC (1993) suggested that district nurse education might, in future, presume a direct progression from first level ('Project 2000') training (UKCC 1986). Proposals for health visitor preparation presumed it would be necessary to introduce new concepts, and develop from any of the four branches of first level registration. It was felt that studying these two different groups will offer broad insights into the educational needs of community nurses in general. Five overall aims were established, which would be achieved through a three phase study design.

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Research Aims

1 To describe what clients/patients, service managers, purchasers, teachers and practitioners mean by the term 'needs assessment' in the context of community nursing.

2 To describe how current educational provision relates to needs assessment (content and process) for district nurses and health visitors.

3 To assess how current educational provision relates to needs assessment in the light of changes contained in the NHS and Community Care Act 1990, with particular reference to inter-agency collaboration.

4 To identify models of good practice in needs assessment, bearing in mind quality assurance requirements and the differing viewpoints of service users, purchasers, practitioners and managers.

5 To develop recommendations for future educational provision in community nursing programmes, relating to needs assessment.

Research Design

Phase one is somewhat analogous to the situational analysis often used in curriculum planning (Skilbeck 1982). Chapter 2 will explain how data drawn from a series of eight focus groups were used to guide and augment the literature review which is drawn together in Chapter 3. This phase concentrated on exploring and clarifying what is meant by 'needs assessment' from a multitude of different viewpoints in order to gain a breadth of understanding; it was used to develop the observational instrument and interview schedule for phase two.

Phase two used a multiple case study design (Yin 1994) to examine the educational preparation and the practice of needs assessment by district nurses and health visitors, and develop recommendations for future educational provision. This phase added a deep, empirical understanding of needs assessment from the viewpoint of community nursing. Chapters 4 and 5 explain the methodological approach, and how data were collected by structured observation and semi-structured interviews, from recently qualified practitioners engaged in service delivery. The idea was to encapsulate the perspectives of consumers in the clinical field (clients/patients) and in education (students), and aspects of quality assurance and purchasing policies through this approach. These data were analysed within and across cases to identify implications for future education provision.

In the final phase of the study, a group of 'experts' from the various interest groups were invited to critically examine and comment on the findings and preliminary recommendations, before these were finalised. In particular, they were asked to consider the extent to which the proposed educational approach seems likely to meet the requirements of intersectoral collaboration, quality assurance and consumer satisfaction. This short phase was instrumental in allowing the depth of understanding gained in the case study sites to be recontextualised within the broader arena, to ensure the final conclusions reflect the whole setting within which community nursing takes place.

The three phases are intimately linked with each other, and the timing of the first two overlapped to some extent. However, for clarity they will be reported separately, with the methods used being detailed prior to the findings for each phase, instead of all together at the start of the report.

The research team

The research design, as illustrated above, was also felt to be representative of the particular strengths and interests of the research team involved in the study.

Ann Bergen, with a district nursing background, has a research interest in case/care management, with the implications that has for needs assessment. Her research experience lies mainly in the use of case study design to investigate matters of interest in nursing.

Sarah Cowley is a health visitor with a research interest in profiling as a means of assessing community health needs; she teaches family nursing, health promotion and public health. Her research background is almost entirely qualitative, with a particular interest in grounded theory.

Kate Young also has community nursing experience and has been involved in research into the organisation of community nursing services, interprofessional collaboration and disability. Her research expertise has mainly been evaluative (quantitative and qualitative), using surveys and geographical approaches to map needs and service provision identified within particular localities.

Ann Kavanagh is an experienced lecturer who is a health visitor and district nurse; she has a particular interest in collaborative working and teaching through reflective and experiential means Her research interests reflect these areas and have previously drawn from ethnographic approaches.

All four researchers have involvement in education for community nurses, and the team as a whole embodies experience in a breadth of research strategies which have been harnessed to the current project. Initially, it was the belief of the team that the diversity in their particular expertise and background interests would bring a breadth of critique and methodological strength to the project. Throughout, there have been many (sometimes vigorous) debates and discussions about the most appropriate approaches for collecting and analysing the data. Also, each researcher took lead responsibility at different points in the project, so the most appropriate person could guide her colleagues from an informed viewpoint. This 'lead person' eventually took responsibility for drafting the part of this final report relating to that part of the project, so some stylistic differences may be discernible throughout. By the end of the process, it became clear that the differences had, indeed, been a strength; however the shared commitment to the research endeavour, and to community nurses and their clients proved equally important.

PHASE I

2. FOCUS GROUPS

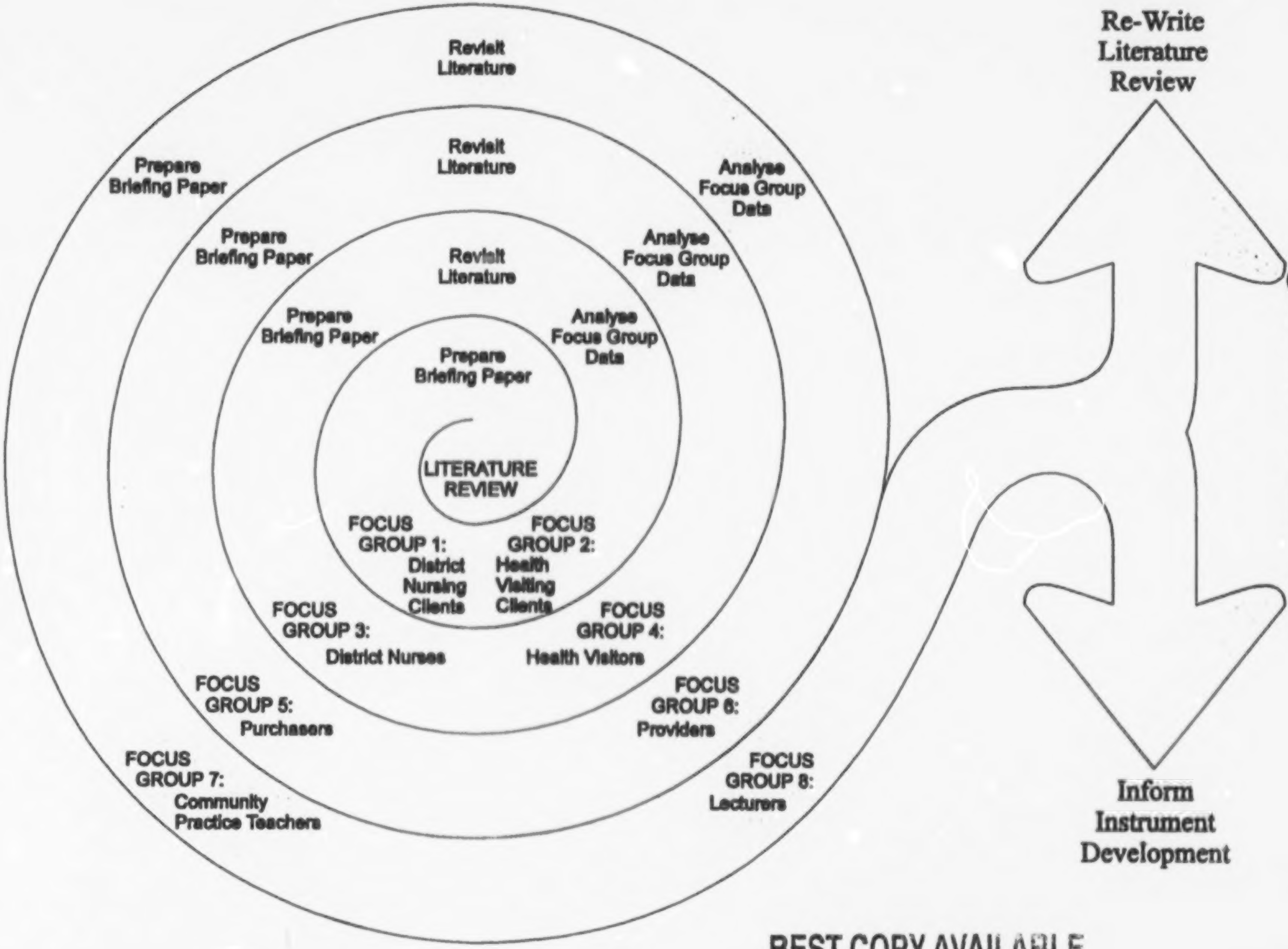
INTRODUCTION

When writing the research proposal, a literature review of research studies which were relevant to needs assessment was undertaken. This review was used to produce a summary of the issues relevant to needs assessment and the NHS and Community Care Act 1990. The literature found was both immense (subject to multiple interpretation and lack of consensus) and partial (as it was a phenomenon under rapid change) (Cowley et al,1996). The research team were aware from their previous work (Bergen,1995; Young,1991) that there is sometimes a considerable gap between policy statements, and how they are implemented in management and practice. In an area such as needs assessment, where different perspectives are widely evident in the literature, it was thought that the potential for a policy-practice gap was large. This in itself presented an interesting research problem: the first phase of the project needed to acknowledge the role of policy guidance documents, but incorporate to a sufficient degree other practice issues which were believed to be of equal relevance to the practice of needs assessment.

In view of this, phase one was planned with a view to achieving a clearer focus for the literature review and the research study as a whole, as well as beginning to meet the first research aim of describing 'needs assessment' from the viewpoint of the various stakeholders.

Focus groups can be used as preliminary research to prepare for specific issues in a larger project (Morgan,1988), and in this study they were used as a part of a full situational analysis (Skilbeck,1982). They generated data which were used to augment and clarify issues explored in the initial literature review, to ensure that the changing nature and current practice of needs assessment was understood, and to prepare observation and interview instruments for Phase II of the study. Chapter 3 presents the focused literature review which resulted from the situational analysis described in this chapter.

This method of interview was chosen as it offered the opportunity for expert discussion and clarification of complex issues such as needs assessment (Carey,1995), allowed a peer review of diverse practice situations in a climate of change (Straw and Marks,1995), and maximised access to a variety of views within a short time period (Henderson,1995). Focus groups also have the advantage of being data rich, flexible, inexpensive, stimulating to respondents and cumulative and elaborative over and above individual interviews (Fontana & Frey,1994). Figure 2.1 summarises the sequence of events which were followed; further detail about these different stages will be given below. Chapter 3 will present the literature review which resulted from this phase of study.


Revisit Literature
Revisit Literature
Revisit Literature
Prepare Briefing Paper
Analyse Focus Group Data
Prepare Briefing Paper
Analyse Focus Group Data
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Analyse Focus Group Data
Prepare Briefing Paper
LITERATURE REVIEW
FOCUS GROUP 1: District Nursing Clients
FOCUS GROUP 2: Health Visiting Clients
FOCUS GROUP 3: District Nurses
FOCUS GROUP 4: Health Visitors
FOCUS GROUP 5: Purchasers
FOCUS GROUP 6: Providers
FOCUS GROUP 7: Community Practice Teachers
FOCUS GROUP 8: Lecturers
Re-Write Literature Review
Inform Instrument Development

Figure 2.1: Phase One

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DEFINITIONS, HISTORY AND LITERATURE REVIEW OF FOCUS GROUPS

Focus groups are essentially a participative, qualitative research method for gathering data from a subjective or emic point of view. Group interviews are primarily a method for collecting qualitative data using a semi-structured interview guide formulated from the research aims. A facilitator leads, guides, and focuses the group discussion (Stewart & Shamdasani,1990). Their role is to understand, and not to infer, actively listening and only entering the discussion to seek clarification. Data collected provides greater depth of understanding about the topic, context, and about relations of the members of a particular setting. (Krueger,1994).

Their uniqueness lies in the effective and efficient way of securing data from those who have first hand knowledge and experience of the subject under study. Focus groups appear to provide a different view in that they collect multiple perspectives about the same subject at the same time, information which cannot be completely satisfied through other qualitative techniques (Morgan and Krueger,1993). Asbury (1995) argues that the whole purpose and value of focus groups rests on the groups' interaction, since the findings are constructed by participants through the sharing of different perspectives about the phenomenon under discussion. The interaction found in focus groups seem to generate information not amenable to other research methods (Basch,1987).

The group interview was first identified as a method for gaining access to fundamental attitudes for scientific scrutiny by Bogardus (1926), applying the technique in race relations research. The principles and underlying philosophy guiding the practices outlined by Bogardus remain pertinent to-day, in that data collected can provide preliminary explanations and lay the foundations for individual interviews, and complement other methods.

The method of interviewing several participants at the same time was subsequently used to evaluate audience responses by Merton et al (1956) who devised the term 'focused interviews'. Market research companies have since engaged in a long-standing and successful use of focus groups to obtain consumers' views about services and goods. These interviews were undertaken in a structured way by a skilled moderator, and the data were used to guide the development of future services and products (Henderson,1995). Maintaining the confidentiality of company product information resulted in few reports available to the public, so the method was regarded by some with suspicion (Krueger,1995). Drayton et al (1989) suggest that these studies made little attempt to validate focus group findings using any kind of external criteria, and this together with the fact that qualitative analysis at that point remained underdeveloped (Miles,1979), did little to enhance the credibility of the method as a research technique amongst academics (Krueger,1995).

However, Reynolds & Johnson (1978) carried out a comparative analysis of market research questionnaire and focus group data. Despite their methodological differences, focus groups produced the same information as the large scale survey but reflected a more accurate reading of the market. More recently, in a study seeking patients' views about dimensions of nursing care, Thomas et al (1995) report that certain concepts are more likely to occur in focus groups when data were compared with individual interviews. Carey (1995) argues that the presence of a group of people makes it easier to access negative views about an issue. She writes that the social desirability in responding to an interview or survey may inhibit negative responses, whereas they may be supported or even encouraged in a group setting. This is supported by the work of Garbett (1994) and Lankshear (1993).

Literature indicates a growing use in areas of health education (Keller et al,1987; Pucci and Hagland,1992; Quine and Cameron,1995; Basch,1987), health care evaluation

(Schearer,1981; Audit Commission,1993; Murray et al,1994), needs assessment (Bowling et al,1992; Landes and Popay,1993), and nursing (Nyamathi and Schuler,1990; MacIntosh,1993; Lankshear,1993; Garbett,1994). Focus groups have been recommended as a useful method to validate constructs to be studied in nursing research (Kingry et al,1990), and to precede the development of more quantitative measures.

A major issue raised in reviewing the literature about focus groups was the lack of any theoretical framework in most studies (Carey,1995). As a consequence, issues are raised (but not answered) which relate to design decisions, how they are taken, and their impact on data collection, analysis and reporting. For example, Kitzinger (1994) views interaction as the distinguishing feature of focus groups, but on reviewing 40 published reports found no data display of the interactions between participants.

Contemporary forms of group interviews are generally classified as 'focus groups', embracing a broad range of interview approaches whose common purpose is to collect data from several individuals simultaneously. Data do not lend themselves to the form of analysis used in individual interviews and should be sampled and analysed accordingly (Crabtree et al,1993). The unit of analysis is the group, and requires a different approach in analysis (Carey,1994). Fieldnotes about the interactions and non-verbal behaviour of participants are combined with the transcripts of the interview in order to reach an understanding of the effect of the groups interactions on the participants' contributions.

Krueger (1995) writes of the misuse of the term focus groups, arguing that it differs from other types of 'group experience' (sometimes referred to as a focus group) found in therapeutic settings (Robson,1993) or groups designed to improve morale as public relations exercises. Krueger (1995) argues that the purpose of true focus groups differs in that facilitators aims to discover a full range of views from participants about a subject, whereas in therapy or public relations groups, the sole aim is to help clients/ participants. In the latter groups case, problems are discussed in a group setting where the locus of control is mainly with the group with little intervention from the therapist. The more facilitating approach to interviewing which has evolved in focus groups today can be attributed to the work of Carl Rogers (1945).

The main use of the qualitative data collected through focus group appears to be for the purpose of instrumentation (Khan et al.,1991; Anker,1991). Commonly regarded as an exploratory method, Fitzpatrick & Boulton (1994) see the method as providing valuable evidence in their own right, but rarely as a stand alone method, (although this is contested by Morgan,1988; Asbury,1995). Knafl & Howard (1984) write of the different purposes of qualitative studies, ranging from instrument development to theory development. They argue that the difference between these types of studies lies in the process of analysis of qualitative data. Data collected purely for instrument development demand the least rigorous approach to analysis, whereas that collected for theory development require a more thorough, in-depth, approach which should be fully described. Since focus groups are clearly a method of qualitative research, they would appear to be subject to the same considerations as described by Knafl and Howard, and the debate about their ability to act as a methods able to generate theory becomes focused on the ability of the researcher to describe and justify the process of analysis fully.

METHOD

Service managers, teachers, practitioners, and clients were selected for focus group interviews from 5 Regional Health Authorities in England. These were chosen to represent the main constituencies of the topic under study, and to ensure that data about the process and product of learning about needs assessment was as complete as possible. Each of these groups of people was interviewed separately, in a sequential manner as follows:

I. Two groups of clients – Firstly, district nursing clients, and secondly, health visiting clients (both groups of participants selected to represent individual, family or community needs).

II. Two groups of practitioners – health visitors and district nurses.

III. Two groups of service managers – NHS providers, social service managers, and representatives from commissioning agencies (NHS, social services and educational purchasers, and GP fundholders).

IV. Two groups of teachers – firstly, clinical practice teachers for district nurses and health visitors, and secondly, lecturers of district nursing and health visiting courses. These were from the case study sites used in phase II of the research, which will be described in Chapters 4 and 5.

The decision to keep participants separate according to their background was founded in the notion that it was important for each group of people to share a common experience (Asbury,1995), and to recognise that status and prestige affects group dynamics, negatively affecting the contribution of lower status members (Carey,1995).

All representatives were sent a briefing paper containing an explanation of the research study and an information pack. This drew on the approach pioneered by Stocking et al (1991) and was intended to stimulate thought and encourage questions, whilst ensuring sufficient knowledge about established roles and the requirements of the new legislation. Preparation for focus group interviews can prevent 'doorstep' type answers, and increase participant's curiosity, willingness and co-operation (Moser and Kalton,1971). It was primarily given to 'sensitise' participants to the topics where prior knowledge ensures a more informed response (Zellar,1993), and also helps to tap into participants' tacit knowledge (Krueger,1994). Also, the more formal nature of written communication may serve to increase the commitment of the individual to participate (Stewart and Shamdasani,1990).

The information pack included practical arrangements for the day together with a background information paper containing material designed to stimulate participants' thought prior to the interview. The paper for the clients was designed in open question format (see Appendices 1a and 1b) and based in the literature about need. It was written in a deliberately simple style, to aid participants' confidence and utility. The remaining groups were given information papers which became progressively more formal, to correspond to the work and academic culture of those under study (see Appendix 1c). The results of each set of focus group interviews were analysed, summarised and used as a part of the briefing papers for the next set of interviews, so that different perspectives on needs assessment were incorporated into the later discussion groups. Sequencing was planned so that educationalists had access to summaries of all views relevant to needs assessment before they attended their focus groups (Appendix 1d).

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Each group of people was asked to come to the interview to discuss the following areas:

a. What constitutes need

b. What factors constitute a good assessment of need

c. Once need is identified, what response is required from the group of people to which interviewee belongs, and from the subsequent group of people to be interviewed.

In addition, teachers were asked to discuss their own methods of teaching needs assessment.

Recruitment issues

A clear recruitment strategy determined by the research team ensured participants were theoretically appropriate, and purposively selected for the study (Miles and Huberman,1994). Identifying participants was initially determined by the research question, and modified according to the different groups of consumers and professionals involved in needs assessment. Selection of participants therefore concentrated on those groups who represent the "important constituencies "of the topic (Robson,1994): consumers, practitioners, managers, and educationalists. Recruits were drawn from a variety of geographical areas in order to reflect the context and diversities in health and social need across England. Issues of age, gender, ethnicity, race, colour and class were addressed in attempting to provide a cross section of participants from different backgrounds. Recruitment was over-archingly guided by the principle that participants had the knowledge and experience required (Morse,1994), the ability to reflect and articulate, and were free and willing to participate.

There is some discussion in the literature about the most appropriate size of focus groups. Stewart and Shamdasani (1990) report that most focus groups are composed of between 6 to 12 people, although Krueger (1995) argues that smaller groups of 6 to 8 people are increasingly being used as experience shows that this is the most effective size.

Sampling was complicated and time consuming, requiring care and sensitivity in the different ways of negotiating access and making initial contact with potential participants. Accurate sampling contributes to collecting appropriate data, strengthening the credibility of the findings (Lincoln and Guba,1985). Conversely, inappropriate recruitment can reduce optimum focus group participation, compromising the data analysis and interpretation (Carey,1994). The rigorous process of recruitment was intended to address the idiosyncratic nature of the phenomenon, and to ensure consistency in approaches across the groups.

Initial contact with potential participants mainly occurred by telephone, and began the process of setting the scene for the group discussions. Details of the study, the purpose of the focus groups, and the role of participants were fully outlined. This first point of contact was seen as crucial by the researchers, where first impressions can influence the success or failure of the study (Frey and Fontana,1993). It was important that all communication was open and honest in sowing the seeds of trust and reciprocity fundamental to the interactive nature of focus group discussions (Carey, 1995). A summary of the study and a personal invitation to participate followed immediately by fax and or mail. Different modes of further communication (letter, telephone, or fax) provided access to individualised information and afforded time for individuals to think through their involvement before agreeing to participate. This was founded on the work of Mischler (1986), who argued that information and feedback to participants reduces the power differences in interactive interviews, and ensures that participants are accepted as collaborators, enhancing the richness of data collected.

Another feature which was important to the recruitment process was that of access. Meetings were held in London on weekdays and began after lunch to accommodate participants' travel time. Creche facilities provided by students of nursing and health visiting enabled parents to attend. Appropriate facilities and physical access to site and buildings were arranged for disabled participants. Travel expenses were reimbursed in cash on the day, or by cheque later.

The sample

A final sample of ninety one individuals participated in the eight groups. Group size varied between 7 and 15 participants with an average of 11 participants. The aim was to recruit between 8 and 12 participants for each group. Over recruitment was undertaken to address potential sample attrition through non response and non attendance . Approximately 200 -300 contacts were necessary in order to realise the final sample.

Running the focus groups

Each pair of focus groups was overseen by a facilitator and a co-facilitator, as discussed by Asbury (1995). The facilitator was primarily responsible for the moderation of discussion, posing questions, encouraging all participants to contribute, and keeping the discussion focused on the relevant issues. The co-facilitator took notes of non-verbal behaviours and other group dynamics, as well as the main content of the discussion.

Henderson (1995) writes of the importance of facilitators' guides to the outcome of focus group research, and this was developed at two levels. Before the focus groups took place, the research team discussed the philosophy which would guide the facilitation of the groups, and for each individual group the facilitator had several questions, based on the background information papers, which were to be used to aid discussion in the group interview. (The latter can be found at the end of each of the background information papers in Appendix 1.)

The philosophy used in the running of focus groups in this study is stated as follows:

1. The focus group is to be fairly informal, and non-threatening. The facilitator will approach questions in an unstructured, qualitative way, grounded in participants direct experience or in the experience of others known to them.

2. The facilitator will give participants the opportunity to discuss issues indirectly, as well as directly, relevant to need or needs assessment.

3. The facilitator will allow participants to challenge and discuss issues with each other, but, as far as possible, ensure that this occurs in a non-confrontational manner.

4. The facilitator and co-facilitator will refine ideas by questioning, verifying or summarising at various points in debate.

5. To ensure that individuals do not dominate discussion, questions contained at the end of briefing paper or other important issues will be re-phrased and re-directed to quieter members, especially if some of them seem to be having difficulty in participating in group. For example:

> What do other people think about this?
> Has anyone been in the same situation and had a similar experience/different experience?

or if appropriate:

> Can anyone think of a reason why this might have happened?
> I'm interested to know whether any other people have experience of this....

At all times, the facilitator kept in mind the research questions and study purpose, as recommended by Henderson (1995). This ensured that tangential discussions were avoided during the course of the focus group interviews.

Carey (1994) writes of the importance of food, drink and informal conversation in providing a relaxed environment prior to interview. Each of the groups began with a half hour pre-session of tea and coffee, which was designed to reduce participants' anxiety. The length of focus groups was approximately 2 hours, but the facilitators often had difficulty in closing discussion due to participants' enthusiasm about the issues and reluctance to finish the session! The use of a short break, timed to minimise disruption to the discussion at about the halfway stage, was also helpful in allowing the facilitators time to review the progress of the discussion, and to help plan the remaining time. The use of a summary by the co-facilitator at the beginning of the second half of the session seemed to refocus the discussion and allow additional comment from quieter group members, thus avoiding the danger of 'groupthink' (Janis,1972) occurring due to the influence of dominant members as described by Carey (1995). It also aided concentration, and relaxation in the group as a whole.

Discussions were held in a brightly lit room where seating and furniture was arranged to promote an environment conducive to sharing. Attention to proximics and other forms of non verbal communication both informs and sets the tone for the interview (Fontana and Frey,1994).

Henderson (1995) writes of the importance of good audio tapes in the analysis process, which she argues are central to gaining a true understanding of the focus group findings. The interview was taped by the audio-visual unit at King's, using several microphones placed on a small table. They were at a low level and were screened by plants to ensure that any feelings of 'threat' to participants were minimised. This ensured that the tapes were of a high quality, and accounted for variations in acoustics and voice levels in the room.

Analysis

Team meetings were held following each focus group evaluating the effectiveness of the approach and also served as debriefing sessions. The facilitator and co-facilitator most involved in the group shared their initial ideas and impressions, and discussed the field notes with the other researchers. The process helped to develop a consistency among researchers in the process of analysis and interpretation across data sets, in ensuring the adequacy of the data (Denzin & Lincoln,1994).

Following transcription of the interview tapes an 'overview' approach to analysis of the data was undertaken (Strauss,1987). These transcriptions formed the basis for the analysis (as recommended by Henderson,1995), so that selective perception was avoided and the full range of responses was recovered. The use of fieldnotes in the analysis ensured that the findings reflected the important role of group dynamics and interaction in the groups, as recommended by Carey (1995) and Asbury (1995). An example of the focus and content of the groups can be found in Appendix 1. Items of data compared in and across the focus groups helped to establish conceptual categories and provided a beginning 'cross check' for the deeper analysis required in instrument development (Field and Morse,1990).

Emerging themes were integrated with the literature on needs assessment and formulated the background papers, informing the questions for the next group of participants. Selecting the main questions to be considered by each subsequent pair of focus groups ensured that analysis and data collection were intertwined (Miles,1983). The incremental nature of the background papers enabled new knowledge and the developing literature to be combined, encouraging early synthesis of the data (Morse 1994), and further conceptualisation. Although the time frame of the study meant limited time for analysis of any pair of groups, Carey (1995) writes that a quick turnaround of groups facilitates the analysis, because it ensures that the group processes are remembered and form an important contribution to the 'rich information' contained in the findings. This approach became a mechanism for informing and verifying the findings with the next group of participants (Carey & Smith,1992, Schatzman & Strauss,1973). The continuous monitoring of the processes of data collection and analysis helped in securing the fitness of the data (Guba,1990).

Research and documentary analysis provided the conceptual framework from which the group interview topics were developed, contributing to the appropriateness and credibility of the data collected (Lincoln and Guba,1985).

Since then, each member of the research team performed a thematic analysis of the focus groups, and these findings have been used to design the research instruments for phase two.

This approach to the analysis is summarised in Figure 2.1

FINDINGS

Each of the groups showed some evidence of differing types of service across the country, but there were striking similarities in what was said both within and across the groups.

The Clients

Definition of Need

The clients commented that need is a very broad concept, covering all of the things basic to life. It was interesting to note that the initial list they produced - money, housing, food, warmth etc. - consisted mainly of physical requirements. However, when asked to consider their own identified needs, they had little problem in articulating what were at once more diverse (extending beyond the purely physical) and more specific (related to their particular situation). The literature also suggests that need is socially constructed and closely bound up with identities, expectations and context (Ong,1991). Clients may define their needs in either a task orientated way, in terms of discrete episodes of care, or in a more holistic way, which fails to differentiate physical, social and psychological aspects.

Some of the clients disliked the term 'need' itself, since they thought it had negative connotations when interpreted as being 'demanding' or 'needy'. It has been noted that a problem focused assessment may have a detrimental effect on the morale of clients and may result in situations being identified as problems which had not been considered in that way (Caldock,1992).

Clients talked about the way an awareness of need may not always become manifest until it has become overwhelming, when, as one participant said: "you're well into the process of dealing with it yourself". Certainly this idea that a need is 'felt' (even if not expressed) is one notion put forward in the literature on need classification (Bradshaw,1972).

Here are some of the needs the clients highlighted:

For the disabled:

- Practical/physical help - bathing, accessible buildings, transport
- An increased public and professional awareness of disability issues
- Access to specialists, professionals, aids and equipment out of normal hours
- Independence, normality and dignity
- A quick and responsive service for unexpected crises.

For carers of disabled:

- Practical help
- Recognition
- Emotional and social support
- Out of hours service
- Procedures for dealing with crises.

Carers of young children:

- Access to services at convenient times.
- Support - someone to "be there" and "listen to you", not necessarily to "do things to you"
- Respect and acknowledgement of experience and expertise
- Information - a resource
- Choice and continuity of health professional
- 'One-stop-shop' - a central point to approach for any health related need.

Some needs highlighted in the literature which clients want from health professionals are:

- Dependability
- Punctuality
- Flexibility
- Continuity
- Intimate knowledge of the care recipient
- Social competence - a professional and caring approach (Ong,1991).

The clients in the focus groups agreed that these were important to them.

Recipients of health visiting services were also concerned that emotional needs should not be overlooked - those such as support which, traditionally, health visitors were practised at meeting, but which were not visible or directly measurable. It was felt to be important that managers should listen to professional practitioners in this respect, since they had a good knowledge of individuals, families and communities.

An area of concern for the clients in securing adequate assessment from community nurses was the potential for conflict, both between clients and professionals, who saw things from differing perspectives, and between clients and carers. The recognition that carers have needs distinct from (and often in conflict with) those of the client, gave rise to a debate as to whether they should therefore be assessed separately or whether this may break the reciprocal trust and openness that existed in a close carer/dependant relationship. There is a further issue of potential differences between managers and either practitioners and clients and the government has noted conflict generally to be an area of concern (DoH,1993). Since the focus groups took place, the Carers' Act (1995) has established the importance of ensuring that there is a separate assessment of clients and their carers, and aims to ensure that provision takes account of carers' needs.

The Process of Needs Assessment

The clients had a number of ideas about the way needs should be assessed at both a community and an individual level.

Both groups thought a general awareness of the community by managers was essential, whether this was achieved through visiting health centres etc. themselves or using survey data to collect information on numbers of clients in specific groups (pregnant women, children with special needs etc.). One group felt managers should be drawn specifically from the same health background as the practitioners they manage, so that they shared their cultural viewpoint. Another point made by both groups was that managers should directly access client views by involving them in consultative planning groups and acting on their recommendations.

There is a requirement in the legislation that agencies should seek client views when deciding which services to provide, and there is an assumption that the views of service users and carers will be taken into account by the professional assessor when planning the particular package of care at an individual level. There were some positive reports in this regard, but some clients reported a degree of 'tokenism' in respect of service consultation.

The clients were not sure that a population-wide assessment of needs using statistical datasets could really work, since it took no cognisance of the personal, subjective element of need. They expressed mistrust of 'managers' undertaking this level of assessment, but they were not entirely sure that district nurses should have to identify needs at an area or community level either, since they were perceived as being already 'overloaded.'

The literature supports much of what the clients said. It suggests that managers use a wide range of sources of information relating to population needs, including extrapolating from national data and more local surveys (DoH,1993). It further suggests that this should integrate with individual needs information in the shape of carers' and users' views, individual professional assessments etc.

A major concern, again voiced by both groups, was of the budgetary constraints that potentially limit managers' response to need and hence may colour their approach to need identification. The issue of falsely raised expectations in assessing needs was very evident and one mentioned in the literature. This suggests that the use of information in a piecemeal fashion results in provision which is demand, rather than needs, led (Jacoby,1990).

The issue of how to bring needs to the attention of professionals brought forth some degree of agreement from the groups. They both mentioned the merits of self-initiated action through self-help groups and the like but at the same time found asking for help was sometimes difficult, particularly for people who were not articulate. This was also difficult where people were not sure of what services were available or no professional contact existed. There was, therefore, a need for an enabling role from professionals to help people realise their needs. This duality is reflected in the literature; studies have discovered that some clients like to be proactive in bringing needs to the attention of district nurses and health visitors, while others prefer the professionals to set the parameters (Ong,1991; Chalmers,1993).

Another interesting area of tension was seen in the view about assessment formats. 'Checking' in the sense of 'seeing you are all right', was seen by health visitor users as useful as these professionals know what to observe. However, it was also seen to have negative connotations in the sense that it could become 'checking up' ('snooping') or seen as adopting a 'checklist mentality'. The literature reports that many community nurses use structured, established instruments, such as the Barthel Index, CAPE, carer stress ratings or an explicit nursing model, such as Roper. The limitations are acknowledged although they can provide useful and well validated frameworks.

Clients saw the process of being assessed by professionals as less than ideal. They would have liked to have been accorded more 'respect' for the views they expressed, and for the knowledge they had gained about their own situation. They wanted a caring, supportive attitude, which avoided stereotyping by client group, and the promotion of a true partnership with the client. Clients thought that 'getting to know' the user was crucial to the process of assessing needs. It was felt that this could only come about when there was continuity in the professional/client relationship, since change was perceived as creating instability. The literature suggests that the 'getting-to-know-you' approach, though user friendly, can be time consuming and problematical for practitioners (Richardson & Higgins,1991). These drawbacks may explain the increasing use, in both health visiting and district nursing, of explicit criteria and documentation of need in order for clients to access a service.

In addition, policy documents that offer guidance to implementing the new approach to needs assessment tend to be prescriptive rather than facilitative; they emphasise the dissemination of information, making service provision clear and explicit, and specifying how assessments are to be documented (SSI,1991). There is an assumption that assessment might be carried out successfully in a single encounter.

This differs radically from the former 'nursing process' approach, in which assessment is viewed as a continuous monitoring activity, integral to all nursing activity, and seems to be contrary to the wishes of the consumers in our discussion groups.

Some of the clients also identified problems in needs assessment and multi-disciplinary care associated with the organisational structure of the service. Multiple assessments occurred where clients lived 'on the boundaries,' and when contracts were changed from one provider unit to another. Some of the clients wished to have a say in which district nurse or health visitor was 'allocated' to them - either because they did not like the person who had been sent, or if they wanted to retain links with staff that they knew and liked, rather than losing them because of moving house or changing doctors.

The clients were interested to know how community nurses saw themselves as members of teams, because they identified a major role for liaison work with other professionals in meeting needs. Some felt it was unhelpful to have too rigidly defined boundaries between professions and thought that nurses may feel threatened as members of teams. However, there is some unease expressed in the literature related to the prospect of nurses adopting fluid role boundaries where this means taking on tasks outside the nursing remit (Ong,1991).

The clients made a few other specific points about needs assessment and how it can be developed. One idea was to use liaison workers, not necessarily with a professional background, but with a working knowledge of a given locality, who could bring needs to the attention of community nurses. Another was to have disabled people visit nurse education establishments to promote disability awareness and to have community nurses do the same in schools in order to educate the public.

The Practitioners

Definition of Need.
The practitioners in our groups also recognised the breadth and diversity of the concept of need, but some commented on how an individualised approach was constrained by 'official' views that some perceived needs might merely be 'wishes'. They reported being advised that these should not be assessed as needs, although none had been given any guidance about how to distinguish between these two concepts.

Another issue which was raised by practitioners was that of 'hidden' or unacknowledged needs. These tended to refer to potential needs, which may be averted by timely intervention (like support following bereavement), or to needs which did not seem to 'fit' the established services, like out-of-hours provision, or someone to listen, support and generally 'be there' for the carer or parent.

As with the clients, a concern was expressed by the practitioners that assessment of need was really linked to the available budget, and the current services. The Children Act requires suitable provision to be made for children designated, through a process of assessment, as having special needs. The Community Care Act, likewise, requires a package of care to be devised to meet assessed needs (DoH 1989a). In each case the assessment is clearly intended to lead to action and responsibilities are explicit. However, our clients were wary about how these explicit responsibilities might colour perceptions of need among service planners, and the practitioners identified many local difficulties when resources were stretched.

The Process of Needs Assessment.
The search for health needs in a population was articulated as a function of health visiting over fifteen years ago (CETHV 1977) and of district nursing more recently (Mackenzie,1989; Pritchard,1991). This activity is supposed to generate a profile which documents an assessment of need at the community or caseload level. These

profiles have been flagged as essential for practice for facilitating prioritisation, ensuring equity, evaluating the quality and effectiveness of approaches and so practitioners could influence policy decisions (Hunt,1982; Goodwin,1988; Twinn et al, 1990). The practitioners did not seem to have any experience of the data they gathered being used formally to inform service provision, but they gave examples of how they had used it to support particular approaches to practice, or requests for appropriate staffing and equipment.

The district nurses themselves recognised the importance of this community dimension to needs assessment, but expressed little familiarity with the process. This has only recently been incorporated into courses of preparation, and our findings might reflect this. Indeed, research shows that this activity has not been evident at either a health authority or practitioner level (Young,1991), despite its prominence in the literature.

The health visitors endorsed the view that documenting the needs in a profile was often a low priority when they were busy, although some talked of reorganising the way the information was collated so that it could become a 'genuine' working document. However, they talked of prioritising and planning their work in accordance with needs identified in their particular caseload area. Some expressed concern that increasingly close attachment to GP practices (since the advent of fundholding) was reducing their ability to assess needs at a community level. The difficulties arising from incompatible boundaries for datasets have been noted in previous research (Chase and Davies,1991; Young and Haynes,1993).

Organisational Issues.

Social service departments were given the lead responsibility for co-ordinating need assessment by the NHS and Community Care Act, 1990, but joint working is mandatory and both health and local authorities were required to have joint agreements in force for integrated assessments by December 1992. The district nurses were, perhaps, more familiar with these than the health visitors in our group, who frankly doubted the research which found that almost three quarters of authorities had complied with this directive (Philip and Dunleavy,1994). However, the health visitors were aware of arrangements for joint working in respect of the Children Act, 1989.

Problems of role demarcation issues and communication between social services and nursing agencies are well documented (Brunnen and Korczak,1993; Rodrigues,1992; Squire,1993). The practitioners described both duplication and gaps in the service. Issues about continuing accountability raised concern, particularly for practitioners who reported feeling they had no control over future service provision and no way of deciding if a further assessment was required.

As demonstrated in the literature (Higgins et al,1994), the practitioners recognised that the 'personal touch' often served as the key to successful joint working, although this was only just evolving in many areas. Once practitioners had met and come to know colleagues from different agencies, it seemed easier to begin to collaborate meaningfully, to develop shared assessment documentation and to trust one another's judgement. This seemed equally true when considering joint working with voluntary agencies, some of whom were represented in our client groups.

While practitioners denied emphatically that a full assessment of need could usually be made in a single encounter, they nevertheless reported having contractual requirements that required this of them.

The importance of both clinical supervision and peer support were highlighted in the focus group discussions as essential elements in the process of assessment. This was particularly evident when there were areas of conflict, perhaps between different needs within a single household (e.g., carer and patient, child and parent), if perceptions or priorities differed between assessors from different agencies or service users, or where there were unresolved views about responsibilities for meeting agreed needs.

The importance of clinical supervision has been highlighted in policy documents (NHSME 1993), but some organisational changes were identified as problematic in this regard, particularly where practitioners were based in multi-disciplinary teams without peers or managers of their own background.

Managers and Purchasers

Definition of Needs.
Some of the purchasers defined 'needs' as that which can benefit from service provision, commenting that the public sometimes held inaccurate beliefs about the function and responsibilities of services. However, there seemed to be a slight trend towards managers suggesting that need is best conceptualised as 'what the client says it is', acknowledging that need is variable and personal in nature.

Provider managers (like the practitioners and clients) seemed acutely aware of the potential dilemma posed by meeting explicit requirements (or 'needs') within a limited budget, but suggested two positive ways forward. Some social service managers reported negotiating with clients, both explicitly recognising the extent of unmet, assessed need, and being open about the extent of service provision that was possible within the resources. They had feared angry demands from the clients, but reported relief and co-operation from them. Further, the managers stressed the importance of ensuring that service deficits were recorded and articulated in a 'politically acceptable' way to purchasers, so that the service would be dynamic rather than static, and could become responsive to identified needs. In turn, the purchasers stressed the importance of receiving clearly articulated statements of need and how service providers could respond to these. The importance of identifying outcomes was emphasised.

It was, however, recognised that 'prioritising' within an established budget would continue for the foreseeable future, so inevitably some gaps in service provision would continue. Echoing Richardson's (1994) view that building an explicit framework of values should precede the technical component of needs assessment, the purchasers emphasised the importance of community nurses establishing an ethical and moral basis for their assessment strategies.

Managing the service.
Some of the managers considered that an assessment might constitute part of a service provision; indeed they noted that in some cases it may be all that is required. Social service organisations have not all implemented the clear division between purchasing and providing, and GP fundholders are recognised as taking both parts. Thus, the separate functions implied in policy and the literature appears much less clear in practice.

In contrast to the practitioners' view that the data they collected for community profiles was not being used to inform service delivery, some of the purchasers explained the importance of obtaining 'soft' data from community nurses that would support their own readily available statistical and epidemiological data. Managers stressed the importance of practitioners providing them with data from individual records, so that it could be aggregated to provide them with evidence to purchasers of unmet need. Despite the concerns raised by practitioners about GP attachment reducing their ability to assess needs at a community level, few managers regarded incompatible boundaries for datasets as a difficulty worthy of attention.

The problems of multi-disciplinary working both within and across agencies was something that was largely unrecognised by purchasers. They tended to attribute concerns about this to the practitioners inability to adjust to their changing role and regarded it as part of a transitional phase. They believed the informal approach to working with other professions was unhelpful. Although practitioners believed that meeting and getting to know their colleagues from different agencies was useful in collaboration, some purchasers felt this encouraged over-dependence on 'individual personalities'. Providers valued the informal approach to collaborative working more than purchasers, but also expressed frustration about problems which existed in achieving good collaborative practice.

Despite government emphasis on collaboration between services and the development of locally organised strategic plans, some of the provider managers complained that a kind of 'strategy gap' could arise. Examples were given of situations where purchasers neither collaborated with them, nor took account of identified needs or policy documents, like the 'Health of the Nation' (DoH,1992).

The provider managers and purchasers each repeatedly emphasised the importance of community nurses learning to be flexible, innovative, able to respond positively to changing circumstances and to work within the new legislative framework. These abilities seemed to them to be essential aspects of the assessment process.

In common with clients and practitioners, managers agreed that assessment of needs could not usually be made in a single encounter, but also reported having contractual requirements that were based on this premise.

Community Practice Teachers and Lecturers

These focus groups recognised many of the issues described by the previous groups, although the lecturers were less clear about practical details of current assessment practice.

Very little new information was revealed in these group discussions, and this, together with repeated patterns in the data produced, indicated that the data had reached a point of saturation.

Lecturers described a process of teaching about needs assessment which was varied and spread throughout the curriculum, across a number of different courses. Students were given opportunities to use case material for discussion, analyse different assessment forms within students' Trusts, profile their practice area, and examine needs assessment in the light of recent policy. Lecturers expressed difficulties in teaching such a rapidly changing phenomenon, and believed that this itself demonstrated the importance of concentrating on the principles underlying the assessment of needs. They echoed the view of managers in their desire to help students' establish an ethical framework and understanding to guide professional practice, especially in the area of needs assessment.

Integration of findings on Need and Needs Assessment

The focus groups produced detailed data about the concept of need and needs assessment. Clients, practitioners and managers have discussed these issues and common themes emerged for use in developing the research tool. The data seems to suggest that the term 'need' signifies a dual concept:

- it is variable, personal, subjective, immensely changeable according to context and is sometimes hidden or barely visible. However, these elements are amenable to articulation at least to a degree

- it is capable of precise specification and sometimes measurement; these elements can be recognised and recorded with a high degree of agreement ('inter-rater reliability') expected between trained assessors

Whilst these elements may appear contradictory at times, it may be argued that any assessment would be incomplete unless it encompassed both aspects of need. Thus need may be measured precisely, but have little real meaning unless it is at the same time framed within personal, social or environmental context.

While it is possible in the abstract to articulate the 'dual aspects' of need, the data did not suggest that the concept could be separated into two distinct parts in reality. The different elements of need merge, possibly imperceptibly, into one another as shown in Figure 2.2. For example, many measurement tools designed to ensure that needs are specified in a standard way try to capture the subjective, personal and dynamic nature of need, as well as recognising cultural, familial and societal factors influencing need. Alternatively, a need which could be articulated explicitly in great detail by clients or carers, may remain hidden because of cultural or other factors influencing their expectations or desires. Definitions of need (whether by clients, carers or professionals) may vary because of the differences in emphasis given to the various elements shown in Figure 2.2.

Additionally, needs assessment should be purposeful (the 'for what' criterion described by McWalter et al,1994), and is thus linked to a service response. There is another proactive aspect of needs assessment, which is the service planning element. Without this essential element, services and assessments would risk becoming entirely reactive and eventually incapable of true responsiveness. Thus, 'needs assessment' is a tri-partite venture, and each aspect requires specific, but closely interdependent knowledge, attitudes and skills.

1. To recognise the needs of client being assessed requires a dual knowledge base to correspond to the two aspects highlighted above. This requires

   - a broad awareness of the potential 'specific' needs which may arise, through a knowledge of biology, psychology and pathology, and
   - an ability to appreciate and elicit the huge diversity of human responses and perceptions in different contexts.

2. To assess the needs requires
   - skills to elicit, measure, articulate and record the multiple aspects of need recognised above,
   - a knowledge of potentially available and suitable service responses, and
   - the ability to work collaboratively as required to ensure appropriate provision.

3. To contribute to service planning requires
   - the ability to compile and analyse caseload and community health profiles,
   - skills in accurately recording, reporting and synthesising information for service managers and planners,
   - ability to make finely judged decisions about the relevance, worth and appropriateness of data to be collated,
   - political awareness, and
   - the ability to articulate clearly the needs of clients, and the potential improvement that may be gained through the provision of particular service interventions.

While these stages are listed sequentially they, too, may happen simultaneously, as shown in Figure 2.3. A practitioner seeking to define an individuals needs may develop a fuller understanding of the normal range of human functioning when they compile caseload and community health profiles; and in the same way profiles may begin to have more meaning when the personal context of needs are experienced. Alternatively, an awareness of the degree of service responsiveness may influence a practitioner's recording and articulation of need, and this information may then be used to ensure that evidence is available to show particular service needs are framed in a politically acceptable way.

The findings showed that "needs" and "needs assessment" are both complex phenomena which have elements that can be simplified in the abstract, however these are more difficult to separate in the reality of practice.

The findings from this phase of the study were used to develop a checklist of the activities which are believed to constitute a comprehensive needs assessment. The way this was used for developing the instruments will be discussed in Chapter 4.

Figure 2.2

The Dual Concept of Need

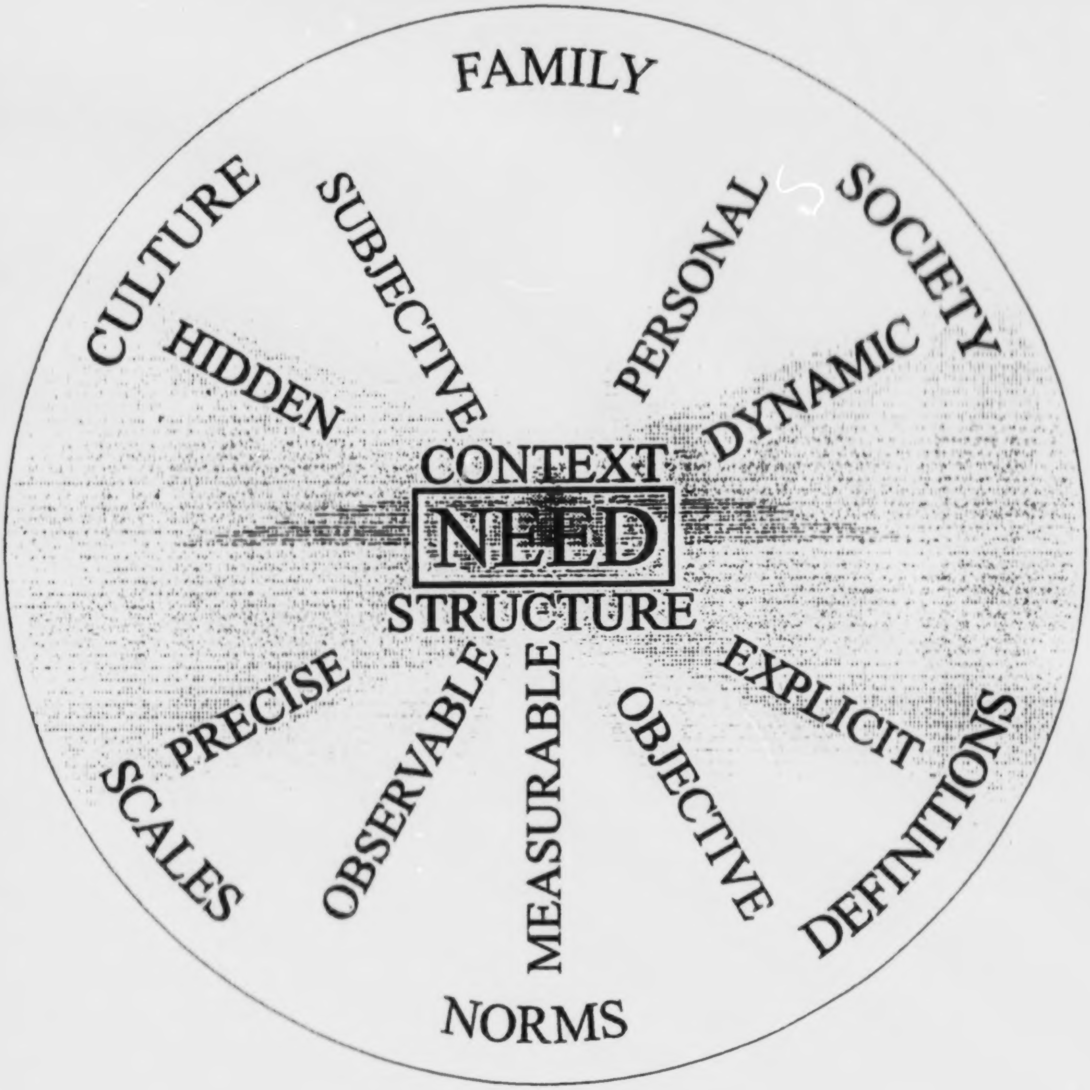
FAMILY
CULTURE
SUBJECTIVE
PERSONAL
SOCIETY
HIDDEN
DYNAMIC
CONTEXT
NEED
STRUCTURE
PRECISE
OBSERVABLE
MEASURABLE
OBJECTIVE
EXPLICIT
DEFINITIONS
SCALES
NORMS

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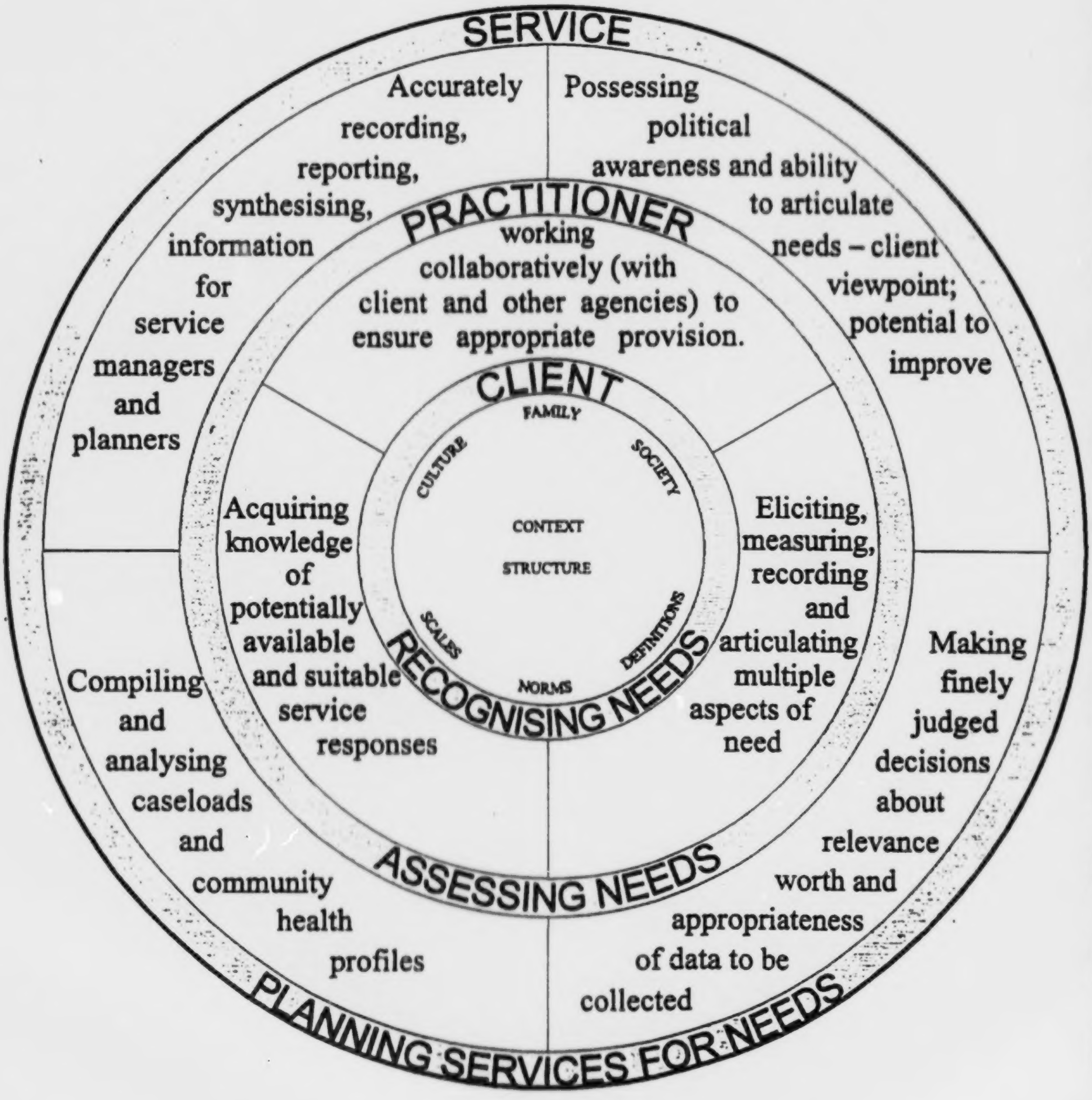
Figure 2.3

Need Assessment: A Tri-partite activity


SERVICE
Accurately recording, reporting, synthesising, information for service managers and planners
Possessing political awareness and ability to articulate needs – client viewpoint; potential to improve
PRACTITIONER
working collaboratively (with client and other agencies) to ensure appropriate provision.
CLIENT
FAMILY
SOCIETY
CULTURE
CONTEXT
STRUCTURE
SCALES
DEFINITIONS
NORMS
RECOGNISING NEEDS
Acquiring knowledge of potentially available and suitable service responses
Eliciting, measuring, recording and articulating multiple aspects of need
ASSESSING NEEDS
Compiling and analysing caseloads and community health profiles
Making finely judged decisions about relevance worth and appropriateness of data to be collected
PLANNING SERVICES FOR NEEDS

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3. LITERATURE REVIEW

BACKGROUND

This chapter will examine the literature about needs, needs assessment and community nursing by looking at the development of policy and nursing literature.

Since the focus groups indicated that the interpretation of policy and thus needs assessment in practice was a dynamic entity, which was subject to multiple interpretations according to personal and professional orientation as well as the purpose for which it is performed, this discussion of the literature will address the core issues of debate between various stakeholders about policy and practice. Where the findings from phase 2 of the study indicate that a more detailed analysis of policy is necessary, this will be presented along with other research studies examining where they influence particular aspects of needs assessment at the end of the next section of this report. This approach to the presentation of the literature examined during the course of this study, ensures that the changes which occurred in policy and practice as the study progressed are reviewed at the point in the research where they appear to be most relevant, reflecting the constant refinement of ideas which occurred in the analysis of new policy and practice.

Introduction

The ability to carry out a full assessment of the needs of individuals, families and communities has always held a central place in the practice of community nursing. As well, the skills of community nurses in assessing needs are integral to the requirements of both the Children Act, 1989 and the NHS and Community Care Act, 1990. However, this recent legislation has changed the emphasis, and perhaps the nature, of practice, with consequent implications for the educational preparation of practitioners.

While proper assessment, together with case management is envisaged as "the cornerstone of high quality care" (DoH,1989) and the skills of community nurses in assessing needs are integral to the requirements of both the Children Act, 1989 and the NHS and Community Care Act, DoH 1990, the nature of assessment is becoming more formalised as a procedure which may confer on consumers the right to receive services and on statutory agencies corresponding responsibilities for their provision. Yet DoH (1993) recognised that in many areas across the country the assessment procedures had developed without first clarifying conceptual issues surrounding the assessment of need. Even at a basic level, there is very limited agreement on the parameters and objectives of assessment (Caldock,1993; Higgins et al,1994). Moreover, the introduction of a commercial ethos and an internal market means that the perspectives of service users (clients/patients in the clinical field and students in education) may differ from those of purchasers.

The nature of need

There has long been recognition that, while an assessment of individual client needs is fundamental to ensuring suitable service provision, the concept of 'need' is itself personal, subjective, variable and constantly changing (CETHV,1977; Crouch,1978; Luker and Orr,1992; Twinn and Cowley,1992). Need is a socially constructed concept, which is closely bound up with identities, expectation and context (Ong,1991; Willard,1982). Each of these factors is crucial in understanding the subjectivity of need. Seedhouse (1994) examines how personal goals and values contribute to different definitions of need, by demonstrating that physical disability may or may not result in need, depending on whether it interferes with the expectations, roles, and relationships of the person concerned. In the same way, individual needs cannot be fully assessed in isolation of

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their social and environmental context. A frail person who lives alone may need services that are unnecessary for someone with a relative who can help, for example. Thus, the 'traditional' community nursing view of assessment has always encompassed the personal, environmental and social context as well as the person's health status or medical condition. This is especially important to avoid 'labelling' and to maximise the use of family and community resources.

Bradshaw (1972) devised a taxonomy of needs, according to who defines need, how it is presented and how it compares with the requirements of others in similar situations. This taxonomy draws attention to the subjective nature of need, and also the potential for conflict or disagreement to occur between and within professionals and between clients and practitioners. Indeed the subject of need forms a central topic for philosophers, sociologists, psychologists, feminists and welfare analysts, with no universally agreed definitions as to its nature. The conflictual nature of defining the needs of individuals and their families and the community was a subject which frequently occurred in the focus group data, and the remainder of this chapter will analyse in more detail why this should be so.

Politicians, economists, epidemiologists, market researchers and managers also offer views about when and how to assess need, but again they differ in the way in which they conceptualise needs assessment. They vary in the degree to which they rely on quantitative, statistical data rather than qualitative aspects of need, and in the extent to which they believe these represent an objective or subjective nature of need. Community nursing assessments have traditionally tended to encompass multiple perspectives of needs, including medical, health and social aspects and the levels of individual, family and community, and these will now be examined in turn, by looking at the professional framework of values which underpin practice.

Individual needs assessment

Community nurses have traditionally taken into account, as far as possible, the personal-subjective dimension of need through an individualised approach to assessment which is the initial stage of the nursing process. Health care professionals also have a role in facilitating situations whereby clients can learn to articulate their needs clearly (Wainwright,1994). Both of these elements emphasise an holistic assessment of clients. Assessment was intrinsically linked with goals, implementation and evaluation of care, and together these formed a mode of nursing based on the continuous monitoring of clients' conditions. While community nursing emphasises the assessing of 'needs' rather than 'problems' (Clark,1986), it assumes that, where a need is identified, the nurse identifying it would take on a responsibility for meeting, or facilitating a response to, that need. The philosophy underlying assessment in community nursing has therefore emphasised it as a process which is inherently a part of all community nursing activity. Recently, McWalter et al (1994) have suggested that assessment cannot adequately be performed without reference to personal goals and service provision.

Community nurses who work with individuals and their families in determining needs may base their assessment to varying degrees on standard formats used in the trust, although many in common usage have questionable validity (Appleton,1996a; Edwards,1995) on a nursing or health visiting model, or may be more biographical in nature (Boulton et al,1989; Johnson et al,1988). Each of these methods requires the use of professional judgement, and the subjective nature of this has been studied in relation to assessment of clients.

Pinholt et al (1987) showed that the clinical judgement of doctors and nurses in a care of the elderly hospital setting agreed about their clients needs for only severe impairment, but that moderate impairment (defined as that identified by research doctors using a standardised tool) was consistently underestimated in different ways by all groups. Although there are methodological problems in assuming that a standardised instrument is able to demonstrate need adequately, this study indicates that assessment activity becomes more controversial as physical needs become less pronounced.

In the community setting, Runciman (1989) conducted a study which showed that general practitioners, health visitors, district nurses, occupational therapists, physiotherapists and social workers assessed the same video of an elderly woman in her own home differently. Although there was broad agreement of the range of problems shown in the video, there was much variation in assessments of their extent and importance, which was influenced both by the practitioner's professional background and their personal interpretation of the situation. Importantly, practitioners of all professional backgrounds in Runciman's study recognised that assessment was a vague and difficult activity.

Yet this does not only apply to finer judgements of need in people who have protracted and complex problems. In an MSc study of a hospital nursing development unit, Harris (1995) showed that experienced nurse practitioners, using mutually agreed, standardised physical and nursing assessment instruments, still showed great variation in very specific areas of technical assessment. For example, it was quite common for these practitioners to record blood pressure, pulse, temperature and respiratory rate in a client quite differently (even where recordings were taken with no interval between assessors), and in some cases this difference could be of great clinical significance. Assessment of a patient's condition, even on simple, everyday nursing measures, is subject to lack of agreement.

These studies show that patient assessment can vary according to professional background, personal experience or prejudice, exists in technical assessment tasks as well as more qualitative measurement activities, varies more considerably for moderate impairment than for severe impairment, and additionally that variations within a profession do not disappear with a high level of professional expertise. Given the multitude of factors which contribute to the complex nature of needs assessment it is unsurprising that research has shown that professional judgements of a person's needs differ considerably, but more surprising that such simple technical measures (hitherto regarded as objective) are open to question.

Family needs assessment

Harrison et al (1991) argue that government policy on community care is founded on the assumption that it is first and foremost the duty of the family to care for dying and dependent relatives, and can be demonstrated by government documents since 'Growing Older' (DHSS,1981). Indeed, there are approximately 6.8 million carers in the UK, 11% of these are caring for 50 hours or more a week (OPCS Monitor,1992).

The assessment of needs in the family as a whole has been identified as a skill which is essential for community nurses (Clark,1986; Friedemann,1990; Orr,1992), although there is a wealth of research to show that carers' needs are not being addressed (Finch and Groves,1983; David and Land,1983; Dalley,1988; Nolan and Grant,1989; Land,1991; Watson and Taylor,1996). The growth in pressure groups which campaign for carers rights have led to recent legislative changes which recognise the carer's right to an assessment of their own needs, as contained in the Carers (Recognition and Services) Act, 1995. Local authorities are now required by law to assess a carer's needs when requested, but with no additional resources to manage or provide their care.

Additionally, the new legislation does not entitle carers to a care package which is independent of the person for whom they care. Where there are good relationships between carer and the client, this is likely to be satisfactory (Grant and Nolan,1993). However, situations exist where the carers needs are diametrically opposed to those in their care (Nolan and Grant,1992), and this may lead to situations in which carers require separate assessments and care packages in their own right, in order that their needs do not remain of secondary importance to those for whom they care. Indeed, the data from our focus groups suggested that clients and carers wanted separate assessments of their needs, which recognised both the strengths and the potential areas of conflict between them (Cowley et al,1996). Similar dilemmas are likely to occur within child protection situations. While the Children Act, 1989 specifies that the need of the child is paramount, this does not relieve health visitors of a duty of care to the parents. Furthermore, health visitors are often involved with families whose situation may give rise to concern, but whose children are not registered as needing protection (Appleton,1996b). Conflicts of interest between different family members are, therefore, a fairly common occurrence (Cowley,1991a).

Bell (1995) reports on the extra problems that the Carer's Act, 1995 is likely to create for local authorities attempting to work within fixed budgets with the potential increase in demand for existing services. He argues that more money is needed to successfully implement the Act. Even before the Act, Ellis (1993) pointed out resource constraints create tensions between practitioner 'expert' led assessments and the ideals of 'user' led care, with the result that clients and carers often have to fight to receive the services they require. This indicates a further area of potential conflict for those engaged in needs assessment.

Thus, family assessment can be a complex area in which a balancing of one person's needs against those of others is required, with prioritising and rationing of care providing a further dimension to this aspect of needs assessment. Indeed, SSI (1991) recognised that it is likely to remain a complex and difficult area of work for community practitioners.

Caseload/community needs assessment

The search for hidden, unrecognised and unmet health needs in the population served was articulated as a function of health visiting over fifteen years ago (CETHV,1977) and in district nursing more recently (Mackenzie,1989; Pritchard,1991). Profiles which document an assessment of need at this community or caseload level have been flagged as essential for practice for facilitating prioritisation, ensuring equity, evaluating the quality and effectiveness of approaches and so practitioners could influence policy decisions (Hunt,1982; Goodwin,1988; Twinn et al,1990). Assessment at this level has also been viewed as a continuous, monitoring activity, integral to any community nursing practice, with the emphasis on process and integration.

Problems in achieving the community needs assessment have been documented, which centre on combining incomplete and sometimes unreliable datasets which relate to fundamentally different subsections of the populations and render different sources of information incompatible (Chase and Davies,1991; Young and Haynes,1993). This level of needs assessment may also be viewed as an activity which has some subjective components, since it depends on the reliability of the datasets used, the amount and types of qualitative and contextual information used, how such data are combined and the interpretations made about the profile produced (Young,1991). The subjective component of this activity can mean that community needs assessment is also open to a degree of controversy amongst professionals, clients and managers.

However, while the benefits of systematic assessments of need continue to be emphasised (Mansfield,1992; Twinn and Cowley,1992), the extent to which the reality of practice lived up to the claims in the literature has been questioned, since profiling activities have not been widely evident at either health authority or practitioner level (Young,1991). As well, the link to action was implicit and not associated with any statutory responsibilities. The new approach to assessment enshrined in legislation challenges the traditional nursing values and places them within a new framework.

NEEDS ASSESSMENT IN POLICY

The NHS and Community Care Act, 1990, was intended to improve the quality and appropriateness of service provision; the concept of 'need' is central in implementing this new approach.

At an individual level, assessment of need is fundamental to the requirements of both the Children Act, 1989 and the Community Care Act, 1990. The Children Act requires suitable provision to be made for children designated, through a process of assessment, as having special needs. The Community Care Act, likewise, requires a package of care to be devised to meet assessed needs. In each case the assessment is clearly intended to lead to action, and responsibilities are explicit. The new approach contained within recent policy tends to give primacy to the professionally defined, normative view of needs, although agencies are expected to seek consumer views when considering which services to provide.

The Disabled Person's (Services and Representation) Act, 1986 emphasises the disabled person's right to an assessment of their needs. In this act, as with the Carers Act, 1995, needs are largely defined by experts, either practitioners or their managers, and the clients' role in defining them is limited. The link between assessment and action is assumed in these acts (Oliver,1991; Bell,1995), but since they place more emphasis on local authority and individual expert judgements about what can usefully be offered to clients, and less emphasis on client involvement in defining their needs than the NHS and Community Care Act, there is a greater opportunity for conflict to exist between professionals and these client groups about what constitutes a legitimate need for a service. However, there is an assumption that the opinion of the service user will be taken into consideration by the professional assessor, although some doubts have been expressed regarding their ability to do so (Bell,1995; Watson and Taylor,1996).

One of the assumptions underlying much of policy is that there can be an objective assessment of need performed by experts or managers on behalf of their patients (The NHS and Community Care Act,1990; The Disabled Person's (representation and services) Act,1986). Yet the research studies about the subjective nature of needs assessment at individual, family and community levels have demonstrated that there are severe problems with this assumption about needs assessment which is likely to lead to further opportunities for conflict.

A common theme running through all of the above pieces of legislation is the view that assessment can be seen as a separate exercise from a consideration of the service response (SSI,1991). This separation between assessment and provision may be seen as a response to the "continuing and growing dilemma of meeting potentially infinite demand with finite resources" (Nolan and Caldock,1996, p77). Indeed, Sir Roy Griffiths (government adviser on community care) and Howard Davies (controller of the Audit Commission) have stated that practitioners must link needs assessment to available resources, thus prioritising needs and rationing care (Community Care, November News, 1989, p7; Social Work Today, January News, 1989,p8-9), which emphasises the relative, rather than the objective nature of needs.

Case Management

Case management represents one attempt in the community to combine the roles of assessor and resource manager (Challis and Davies,1986; DoH,1990), although it does not always involve budgetary control. Beardshaw and Towell (1990) identify 3 main types of case management: Social Entrepreneurship, Service Brokerage, and the Key Worker models. Each can be seen to have various strengths and weaknesses, depending on the precise nature of the roles. Case management (particularly where it incorporates an emphasis on resource management) has been recommended as a way of working by central government (DoH,1989; DoH,1990b). However, there is no single, unifying method of case management and government guidance recommends that it should develop across a range of models "suited to the type and level of users' needs" (SSI, 1991,p74). Community nursing is one of the professional disciplines which has been recognised by DoH (1989) as suitable for the role of case management, yet prioritising care of clients in nursing has previously been based on largely intuitive, humanistic assessment and has not involved a consideration of financial cost to any great extent. The role of case manager, where it involves budgetary control, is likely to produce new dilemmas for community nurses working in this way, and it is an area which is likely to create new educational needs amongst this group of practitioners (Bergen,1992; Audit Commission,1992; Hoyes and Means,1993).

Cowley et al (1996) indicate that financial imperatives are also raising new dilemmas in more traditional community nursing practice which current professional training (with its emphasis on holism) does not address. Indeed, Ellis (1993) links damaging professional behaviour to the difficulties which practitioners face in trying to meet the ideals of service providers within the climate of scarce professional resources.

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The subjective nature of needs assessment activity, and the obligation to prioritise care due to resource constraints, would seem to suggest that there is a role for an ethical framework to guide practitioners in their decision making about needs. Indeed, Richardson (1994) argues that the process of building an explicit framework of values to guide practitioners should precede the practice of needs assessment.

Assessment of population need

Under the Act, assessment of need within populations is viewed as a function of senior management, using epidemiological and statistical data. These assessments, compiled in the health service under the auspices of the Directors of Public Health, and in local authorities under the auspices of the Director of Social Services, are intended to determine appropriate provision and to help provide a baseline against which outcomes can be measured for quality purposes. There is a statutory requirement in the legislation to co-ordinate arrangements for assessing community care needs on an interagency basis (DoH,1990b;SSI,1991) and collaboration is stressed in 'Working Together under the Children Act' (DoH,1991a). This identifies a further area in which the practice of community nursing and its associated philosophy runs at a tangent to policy, since senior managers and community nurses regard needs assessment at community level as fundamental to their role for differing reasons. Both regard profiling as an activity which can lead to a better quality, needs based service, but health visiting and district nursing have tended to regard it as a method to petition for further resources, whilst the purchasers new role emphasises it as a method of increasing efficiency and rationing of resources.

Health and social need

The concepts of health need and social need are regarded in the NHS and Community-Care Act, 1990 as separate, and the responsibility of different agencies. The intentions of this split is to make accountability greater for practitioners and managers in the community, and to achieve a more streamlined process of care with less overlapping activity between sectors (Means and Smith,1994). At first glance this appears to be a sensible policy direction, but there are many difficulties associated with this notion of need.

Out of 35 activities related to house care, diet and food preparation, eating/feeding, washing and dressing, only three were considered to be the sole responsibility of health care: artificial feeding and washing and dressing only in context of severe disability (St Helens Metropolitan Borough Council Personal Services Department,1992). The following tasks were said to be activities in which either social or health services could be legitimately involved:

- Motivating customers in house care, diet and food preparation, eating/feeding or washing and dressing
- Teaching/training customer or carer in house care, diet and food preparation, eating/feeding or washing and dressing
- Feeding assistance
- Dressing/washing assistance
- Strip washing
- Assisting to shower or bath
- Blanket bathing
- Rehabilitation of customer in washing and dressing

It is easy to see that each of these areas were traditionally district nursing concerns by referring to one of the most commonly used nursing models. The activities of daily living, proposed by Roper et al (1985) as legitimate areas of nursing concern, which until recently have commonly framed assessment practice for district nurses is now being challenged by the new role of home helps / home care assistants from social services. The emphasis on holism within traditional nursing philosophy is challenged by this separation of health and social care, and importantly, Hunter (1988) warned that this division between health and social care may worsen the position of clients whose needs could be met by either health or social care agencies. Furthermore, Baldock (1993) discussed the assessment structure and strict criteria for inclusion into care which were developing at that time, and argues that assessment is now a more bureaucratic process than previously.

Because a person's health needs are so closely intertwined with their social needs, defining which category they are placed in may be related to the goals of an intervention. Indeed, Seedhouse (1994) argues that no assessment of human needs can take place without reference to personal goals.

Means and Smith (1994) point out that there is a financial disincentive to agencies working together to assign a range of needs as requiring either social or health care, which adds further complexity to those seeking to define a health or social care need.

The problems in defining health or social needs in a workable way was recognised by the Social Services Select Committee (1990), but there has been no central directives about how to overcome these problems other than government guidelines (DoH,1990b) which reinforce the view that assessment does not take place within a vacuum, but "within a framework of locally determined objectives and priorities" (para.9). The reliance on local arrangements to guide assessment practice, especially when there has been little prior conceptual clarification of what constitutes need (DoH,1993), is likely to result in further controversy about the practice of needs assessment. Despite this, there has been research evidence which suggests that in many areas the health and social services have developed good communication strategies and better mutual understanding of priorities as a result of the community care planning process (Hoyes et al,1993; Martin and Gaster,1993); especially where their boundaries have a high degree of co-terminosity (Hudson,1992).

Thus, the new approach appears to characterise assessment of need in terms of separateness, rather than integration. The levels of assessment (individual and community) and the aspects (health and social need) are separated because different assessors, and different agencies are used. There is a danger that it may be viewed as a single event, rather than an integral part of an on-going process of care as practitioners are urged to view assessment as a separate exercise from consideration of the service response (SSI 1991).

The levels of assessment (individual and community) and the aspects (health and social need) may be separated because different assessors, and different agencies, are involved. Even where interagency collaboration is unnecessary, emphasis on the managerial function of qualified community nurses has led to suggestions that they should concentrate on assessment, and delegate the delivery of care to less expensive nurses in their team (VFMU 1992). Ovretveit (1993) summarises this paradox of the need to 'separate and then link' in order to activate the needs-service response dynamic, a paradox which inevitably makes its operationalisation less than straight forward. This hierarchy of needs assessment and provision may, in itself, create professional and ethical difficulties when practitioners do not agree about need or types of provision required to address need.

CONCLUSIONS.

Need is an inherently subjective phenomenon, which is closely related to the personal goals of an individual (Seedhouse,1994). Likewise needs assessment has been inextricably linked with an acknowledgement of service goals and intervention (McWalter et al,1994). However, recent policy emphasises the separation between different types of needs, needs assessment activity and service provision, based on the view that assessment can be separated from provision. Neither needs nor needs assessment have been defined in a way that commands universal recognition, either within or across professional disciplines. Consequently, needs assessment can be a controversial activity. The extent of controversy varies according to the person assessing need (professional or client), their personal background, professional orientation and experience as well as the nature of the needs they assess.

Much of government policy emphasises consumer choice, and their associated rights to contribute to decisions about their care, whilst often the same policy documents also stress that needs should ultimately be professionally defined. There is little recognition that the concept of need may be perceived differently according to circumstance, or be subjective and variable, with the attendant complexities of classification and analysis that this entails (Cartwright,1983; Bowling,1992). This may potentially create problems for community nurses who try to live up to the contradictory ideals of policy and community nursing, and who also find themselves operating in an area where there is likely to be some conflict of expectations between professionals, purchaser and providers.

The tension in policy between consumer choice and expert led needs assessment may be seen as an attempt to ensure that needs are measured in comparative terms, rather than against any other standards. This may represent a contradiction to traditional community nursing philosophy, with its emphasis on holism and meeting needs, since it creates a link between needs assessment, prioritisation of care and resource management. If this is so, there are likely to be new dilemmas in community nursing practice, which will be amenable to articulation and measurement in practice.

The following chapters of this report record the methods used by the research team to describe current needs assessment activity in health visiting and district nursing, and attempt to identify whether there are any new practical, professional or educational dilemmas which exist as a result of policy or the philosophy underpinning professional practice.

PHASE II

4. RESEARCH DESIGN

SELECTING A METHOD: THE CASE STUDY DESIGN

Phase II of the study set out to build on the findings of phase I. The focus thus moved from the clarification of concepts surrounding needs assessment to a more empirical approach in order to identify how community nurses currently learn about and practice needs assessment. This would provide a basis from which to develop recommendations for future educational provision, thus fulfilling the aims of the research.

A multiple case study design (Yin, 1994) was adopted for this stage, as it met a number of requirements dictated by the particular nature of the research. One major issue was the context-bound nature of need and needs assessment, as identified in phase I, which presented a challenge insofar as it appeared to drive a wedge between the research question and the phenomenon under study, elements which are generally conceptualized as having a linear relationship in 'traditional' research.

Thus needs asessment (the phenomenon under study), reflecting the multi-faceted nature of need identified in phase I, had been seen to incorporate:

1) A purpose/end, ie a possible service response (availability of which is governed by **national and local policy and organization**).

2) A value system embraced by individuals and teams which determine classification, prioritization and processing of need (transmitted by **professional and educational ideals**).

3) The world in which clients and communities live and interact, which may mediate 'objectively' defined need of an individual assessed in isolation (the **social context**).

The research question, which is about how educational provision relates to the phenomenon, must obviously take all this into account. In other words, many variables within the context (policy/organizational, professional/educational and social) appear to intersect the expected linear relationship identified above.

Yin's definition of case study research is able to accomodate this feature, since it is:

> "an empirical study that:
>
> - investigates a **contemporary phenomenon** (in this instance needs assessment)
> - in its **real life context** (the context of community nursing)
> - where the boundaries between **phenomenon** and **context** are not clearly evident".
>
> (Yin, 1994, p.13)

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The implication here is that data from the context are fed into answering the question, rather than being regarded as confounding variables. It was, therefore, planned to collect data on the contextual issues identified above in the proposed research. This is consistent with another facet of Yin's definition of the case study in that:

"• it relies on **multiple sources of evidence**, with data needing to converge in a triangulating fashion (ie on the research question about educational provision for needs assessment)".

(Yin, 1994, p.13)

Using multiple sources of evidence in this way, however, presented another challenge to 'conventional' principles of research, given that data would be collected on a very great number of issues relative to the likely number of sources of evidence. This has obvious implications for external validity. However, another feature of Yin's definition of the case study is that:

"• there will be more **variables of interest** (ie diverse factors affecting educational needs of community nurses for needs assessment) than **data points** (points or individual constituent parts of a sample from which data are being gathered)".

(Yin, 1994, p.13)

The issue of external validity is addressed by Yin within his final identifying hallmark of the case study, that:

"• it benefits from the prior development of **theoretical propositions** to guide data collection and analysis".

(Yin, 1994, p.13)

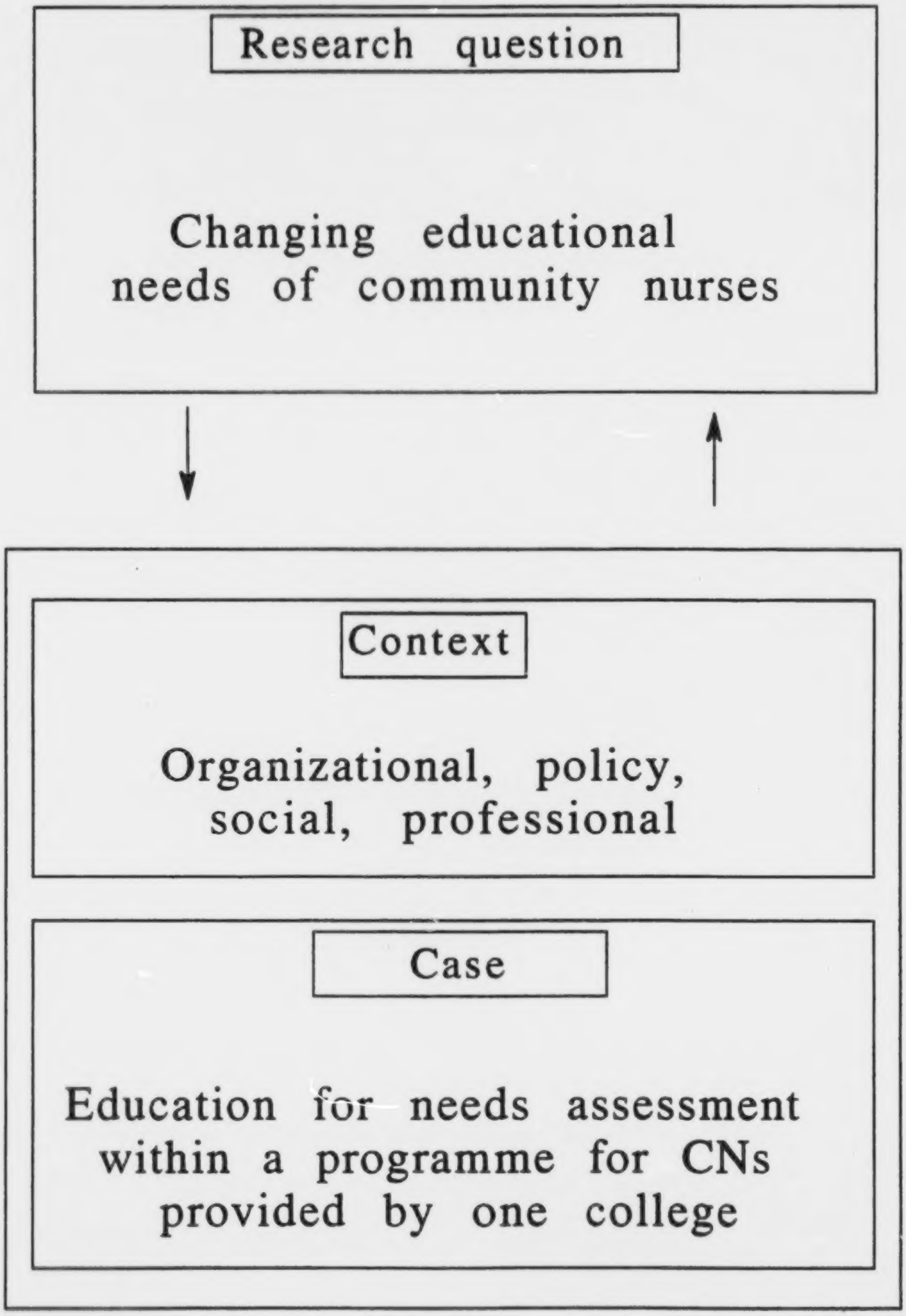
Propositions can be regarded as theory which "directs attention to something that should be examined within the scope of the study" (Yin, 1994 p.21). The current focus was directed by (a) the literature and (b) focus group data and, as well as guiding the content matter for data collection, this focus also guided the research in two major ways which will be discussed below: (1) the **definition of 'the case'** and (2) the rationale for **case selection**, (and it is this which provided the logic for data analysis and external validity, found wanting, as discussed above, on original consideration of the method).

Definition of the case

Literature and focus group data suggested that needs assessment by community nurses is influenced by the contextual variables mentioned above - local, social and professional values and practices. Therefore the case needed to be conceptualized as inclusive of these influences, and was defined as 'education for needs assessment originating within a programme for community nurses provided by one college'. This would circumscribe the case in terms of the values and teaching espoused and passed on by one particular institution and be evidenced in the chosen data sources, mediated by a 'real life' context of policies and individual professional discretion and decision-making (see Fig. 4.1).

However, the study of one case alone, because of its contextual determinants, would not enhance theory in a meaningful way beyond relevance to a particular college course and local setting. Therefore it was decided to use Yin's multiple case study approach to overcome this. Yin considers that evidence from multiple case studies is often more compelling than that from single cases and the overall study is considered more robust. The reason for this is that, in the analysis stage, it is able to work through a 'replication logic' analogous to conducting multiple experiments. Here, results of one case study are compared or 'matched' with the results of subsequent ones. If similar results are obtained, replication is said to have taken place and theory therefore built up.

Fig. 4.1 Case, context and research question


Research question
Changing educational needs of community nurses
Context
Organizational, policy, social, professional
Case
Education for needs assessment within a programme for CNs provided by one college

Case selection

Theory also directed case selection, which extends this logic. In other words, the purpose was not to seek a representative sample so much as to seek cases which would enhance understanding of specific phenomena. Case selection would ideally focus on education programmes where there would be evidence of how this programme impacted upon practice, that is, where graduates of the course were practising as professionals within a given geographical area. It was considered that five cases, representing different geographical areas, would be appropriate, as this would enhance understanding of differing geographical, social and professional contexts and how these contexts affect the phenomenon of interest.

DEVELOPING THE RESEARCH METHODS AND INSTRUMENTS

Within the identified case study framework decisions needed to be taken in order to operationalize the design within the specific remit of the current research. These decisions related specifically to choice of data collection methods and instruments, which will be considered below. The design also influenced sample (ie actual case) selection, which will be described after this.

Data collection relates to Yin's concept of multiple sources of evidence (see above). Sources of evidence should reflect the variables of interest within the case and it was decided that the education programme of a college would be best reflected in the practices of newly qualified practitioners from that course, who would have recently been exposed to these educational values. This, in turn, would be measured through **observation** of their practice, **interviews** to glean nurse perceptions of their education and practice, and through **documentation**, relating to contextual variables.

Development of the observation and interview schedules emerged from the thematic analysis of particular focus groups undertaken by each member of the research team, as alluded to in Chapter 2. The central research questions served as the frame of reference for this exercise, both those at least partly answered by phase one (focus group) data alone, and those to be answered in phase two.

A 'brainstorming' session addressed the issue of what constituted observable and what 'interviewable' data and also identified a number of possible analytical frameworks; these included dimensions of need, assessment typologies, domains of competence (knowledge, skills, attitudes) and identifying data as descriptive, qualitative, prescriptive or 'debatable' and, therefore, how they may be used.

The observation schedule

Observation is the method of choice in research where information is to be collected on activities, communication (verbal and non-verbal), skill attainment and also environmental characteristics (Polit & Hungler, 1987). These had all been identified as pertinent to needs asessment (see above), the environmental characteristics constituting the contextual data which is a necessary component of case study research (Yin, 1989).

Although dependent on a high degree of inference from behaviour, observation as a method has a long tradition in nursing research, where communication skills are being analyzed (for example Bond, 1983) and in the present study will be verified through the complementary use of interviews.

Plans to focus the observation schedule on the process of assessment rather than the constituent skills used during assessment (both outlined by focus groups as essential to assessment) proved an elusive goal. Focus group data showed that whilst it was important **what** practitioners did during assessment, it was at least as important to determine **how** they did it.

At the outset of phase two, it was clear that a series of completely unstructured observations was inappropriate, since this could be used with little consistency or objectivity between observers, participants or case study sites.

The initial draft of the observation schedule was based on stages of assessment identified by McWalter et al (1994) who defined the stages of assessment as follows:

- identify difficulties/problems
- identify potential/hidden problems
- ascertain level of current help
- identify where help is inadequate-unmet need
- prioritise unmet needs
- identify and prioritise help/services needed
- identify limits to provision.

These stages of assessment were combined with the key skills of assessment defined by Maguire (1985), who believed that they are:

- explanation giving
- questioning
- interviewing
- reassuring
- counselling.

Pre-pilot work, using videos of community nursing assessment visits, showed that the process of assessment did not follow strict chronological patterns outlined by McWalter et al (1994), and thus the observation schedule consisted mainly of micro-skills which were removed from the aims of the research study. For these reasons it was rejected as a means of designing the schedule.

Preliminary ideas for the second draft of observation schedule showed that the essential micro-skills of assessment, identified in the focus group data, were very removed from the assessment process, concentrating mainly on communication skills inherent in any nursing practice. Upon pre-pilot work, such a fine analysis of these skills was found to be impracticable, and moreover unhelpful in defining the practice of needs assessment. This pre-piolt work showed that, in order to maintain the focus on the assessment episode as a whole, a highly structured rating scale, breaking units down to the molecular level, would also be inappropriate.

Initial drafts of the schedule also showed that the main categories relating to assessment practice that were shown to be important by the focus group data, were not mutually exclusive. If a structured format was used for such fine, frequently occuring, elements of skill, a high degree of subjectivity would be incurred in the recording process (Burns and Grove,1993), with associated inconsistency of use between researchers. Although the research team recognised that observation may be viewed as an inherently subjective process (Burns and Grove,1993), the use of the multiple case study design required fairly high consistency between researchers, so the nature of the schedule had to be changed.

Brink and Wood (1983) explain how complex, abstract theoretical constructs have many aspects which can be represented in several ways. They argue that different conceptualizations of a construct necessarily leads to varying ways of measuring it, and that no method of measurement is inherently more satisfactory than others (p75). The final schedule contained items (or themes) which were conceived in a different, more qualitative way, since this produces the least limited approach which aims to describe the issue under study in detail (Power and Knapp, 1990). Chapter 2 ends with a description of the integrated findings about assessment from the focus groups. This, together with professional knowledge about community practice, was used as a basis for developing items which described observable behaviour related to the assessment of needs. Instead of attempting to operationalise needs assessment practice *per se*, the research team chose to operationalise each of the statements about needs assessment practice. This ensured that observed behaviour directly related to our focus group data, relying on minimum inference during the analysis stage. This produced an observation schedule which had good face validity. Pre-piloting work with videos showed that it was in theory workable, but needed extensive piloting before each item could be meaningfully operationalised within the research team. This pre-pilot work included 2 further redrafts, and concerted efforts to achieve standardised used of the schedule by all members of the research team.

The redrafted schedule contained items which were not mutually exclusive, but (to reduce problems of consistency and reliability in use) the researcher simply had to record whether items were present or absent, or to state cases where this was unclear. It allowed the observer to record comments for each category, so that judgements as to presence or absence could be made after the observed behaviour if necessary (although in practice this occured rarely). This device also allowed the researcher to take in-depth fieldnotes which facilitated and enriched the observation, and subsequently the interview, data. This 'checklist' of categories was devised, which together, incorporated all the major features and dimensions of need assessment identified in the focus group data.

Access to the case study sites was negotiated during the development of instruments, and the main pilot study consisted of each member of the research team observing practitioners working with between two and four patients (total observations =14). Personal comment about the reasons for classifying observations in certain ways formed a part of the fieldnotes to aid further discussion about operationalisation of each item.

After each member of the research team had performed a half-day observation of the assessment practice of one practitioner, a few minor, single word, adaptations were made to the schedule, based on achieving well operationalised items which could be used with the highest possible inter-rater reliability. Additional filter items were also added to clarify existing observations since these were felt to be important in furthering understanding of the process of needs assessment. This was followed by further pilot work for each member of the research team, and the final observation schedule is contained in Appendix 2.

Reliability and validity

A number of issues emerged from the proposed schedule pertaining to validity and reliability. One issue was that of establishing operational definitions at the thematic level, which would be flexible enough to cope with a wide variety of possible situations and contexts. The focus groups found contextual data to be so embedded in the notion of needs assessment, that achieving this within the schedule was essential, otherwise the view of assessment obtained by observation would be partial. Another issue, in the light of our finding that needs, and therefore needs assessment, varies according to context, centred on the difficulty of gauging the *appropriateness* of features of observed data, which is inevitably a very subjective undertaking. These issues were addressed in the preparation, piloting and analysis stages. A circular process of preliminary discussion, prepiloting by use of videos of community nurse assessments, refining, further pre-piloting, evaluating and redrafting the observation schedule ensured that each member of the research team was involved and had ample opportunities to discuss the meanings and application of themes within the schedule. The development of the observation schedule occured over a period of 5 months and ensured that members of the research team developed a joint understanding of the themes, enhancing reliability of the recording process. Where the use of individual elements were shown to be unreliable, because they were unavoidably subject to multiple interpretations, they were taken out of the schedule. These amounted to one or two marginal components of the process of assessment, which could be subsumed within other observational items. This corroborated our view that, if the observation schedule was to be both meaningful and reliable, it had to occur by a process of measurement which was removed from those micro-skills which have more commonly been the subject of nursing research.

It is important to note that it was not possible to examine the appropriateness of actions, unless focus or expert group data contra-indicated observed behaviour. This was because the research team believed that this would place them in the role of 'Judge and Jury', thus contaminating their role as researchers.

Development of the interview guide

The refinement of the interview guide was based on the outline framework identified in the data collection 'grid' illustrated in Appendix 5, and took into consideration its twofold purpose, indicated above, of supplementing observational data (through expanding and confirming observed phenomena) and accessing data not amenable to that method of collection (for instance attitudes and awareness as well as knowledge and skills). Like the observation schedule, it sought to build on both existing literature relating to needs assessment and the findings from the focus groups which have previously been identified, as well as the observation schedule itself.
A number of authorities have found that the practice of needs assessment is amenable to articulation by practitioners themselves. However, the style of interview through which information is elicited necessarily varies according to the paradigm from which the researcher operates. In seeking an appropriate vehicle for our practitioner interviews we therefore decided against the purist ethnographic approach of Chalmers (1993), since we were not adopting an atheoretical starting point but were rather already informed by the groundwork outlined above. Instead, we looked to the work of Caldock (1993) and other proponents of the semi-structured interview who point to the advantages of key questions, supported by words or phrases to guide the interviewer in probing relevant lines of conversation which may follow. This has the advantage of allowing flexibility, while at the same time, as Jones (1991) points out, ensuring comparable data in order to facilitate analysis. This guided interview, described by Field and Morse (1990), ensured that we were likely to obtain rich data, covering as many aspects of needs assessment and education relevant to this practice as possible.

The interview structure was governed by the need to contextualise the subject of needs assessment from the start within the NHS & Community Care Act. Thus, although the opening was designed to be very general and non threatening, it made early reference to this in order to avoid irrelevancies. The body of the interview followed the process of assessment itself, using one of the assessment episodes observed to focus thinking at a concrete level before moving on to a more abstract consideration of the subject and a discussion of how local structural and organisational factors may affect practice. Finally, respondents were asked to reflect on their recent experience of educational preparation in the light of this.

Initial pilot work revealed the guide to be largely workable as it stood. Though responses were variable, it was felt that the topic guide, supplemented by the given probes plus the facility for interviewer discretion with regard to depth and breadth of questioning, adequately covered the content sought.

A few areas were, however, altered. Firstly, the need to explore the practitioner's philosophy of needs assessment more fully, led to supplementing the opening question with an invitation to reflect on the extent to which it was demonstrated throughout the period under observation (that is, beyond clearly labelled 'assessment' visits). Secondly, although it was found that neophyte practitioners experienced some problems in identifying changes emanating from the NHS & Community Care Act (since none had practised prior to its implementation) the issue was retained as a means to exploring the features of its policy. Finally, some consideration was given to the 'continuum grid' in order to simplify and clarify its administration, after some respondents clearly found it to be somewhat unclear, if not rather intimidating.

The final interview schedule can be found in Appendix 3. The purpose of each of the questions were as follows:

1. Initial thoughts on the meaning of needs assessment.

This was designed to examine the practitioner's personal philosophy, as well as look for an appreciation of the complex nature of need which arose from the focus groups. This, together with the 'continuum' exercise, would serve to help interpret some of the observational data. 'Supplementaries' prompted for acknowledgement of who the client is in the community setting (individual/family/community), what needs are being assessed (health/holistic) and the purpose of the assessment (that is, the service response).

2. Needs assessment as demonstrated during period of observed practice.

See comments above.

3. Knowledge of NHS & Community Care Act from college course and likely changes in practice of needs assessment resulting from it.

This looked for some degree of 'political' awareness and an ability to think through how policy issues might impact on practice. It also sought data on the operationalisation of community care ideals within the case study site and, with 9 and 10, provided some contextual data.

4. Theories of need/need assessment touched on at college.

This sought some basic grounding in the subject of needs assessment and and indication of the extent to which the respondent had considered the subject within any theoretical framework prior to this.

5. Appropriateness of documentation in use for needs assessment.

This item picked up an issue which featured very prominently in focus group discussions. It was thought to be important to include the nurses' own opinions of the appropriateness of the assessment documentation, since it was felt (and later confirmed during pilot work) that a practitioner's behaviour may be largely dictated by the document's format. Thus not only factual information, but also subjective impressions were sought, in order to overcome the limited inferences which could be made from observation alone in this area.

6. The process of needs assessment, including necessary skills and knowledge.

This, together with the following questions were probably the most useful as a supplement to observational data, with the opportunity for clarifying and explaining behaviour and thereby minimising bias in interpretation. They focused on the process of assessment, looking for an awareness of knowledge, skills and attitudes which may have not been demonstrated in the observed visit. The nurse was asked to focus on one client/family/group whose assessment had been seen in order to minimise the risk of the interview being conducted at too superficial or abstract a level.

7. Services provision.

This sought information on knowledge of services available, this being another feature of focus group discussions, and served to supplement observed data where such knowledge was demonstrated.

8. Constraints to meeting identified needs.

An ethical awareness was sought as a dimension featuring prominently in the educationalists' focus group discussions and, again, to supplement observations where a nurse dealt with the service response to identified needs and any difficulties encountered in this.

9. The continuum grid.

This moved back to a more global consideration of needs assessment in the light of the previous discussion and also to force a differentiation between actual and ideal practice. It served as a supplement to 1 but allowing for more comprehensive and well considered responses and focussing more specifically on practice.

10 & 11. The existence of a Trust philosophy and of community profiling practices.

As stated, these sought information on contextual data and attempted to elicit any thinking beyond individual need and individual working.

12. Adequacy of education preparation for needs assessment.

This asked the respondent to reflect back on the perceived adequacy of educational preparation for needs assessment, reflecting on the previous discussion. It also brought the interview to a conclusion, by focussing on the educational remit of the research as a whole.

SAMPLE SELECTION

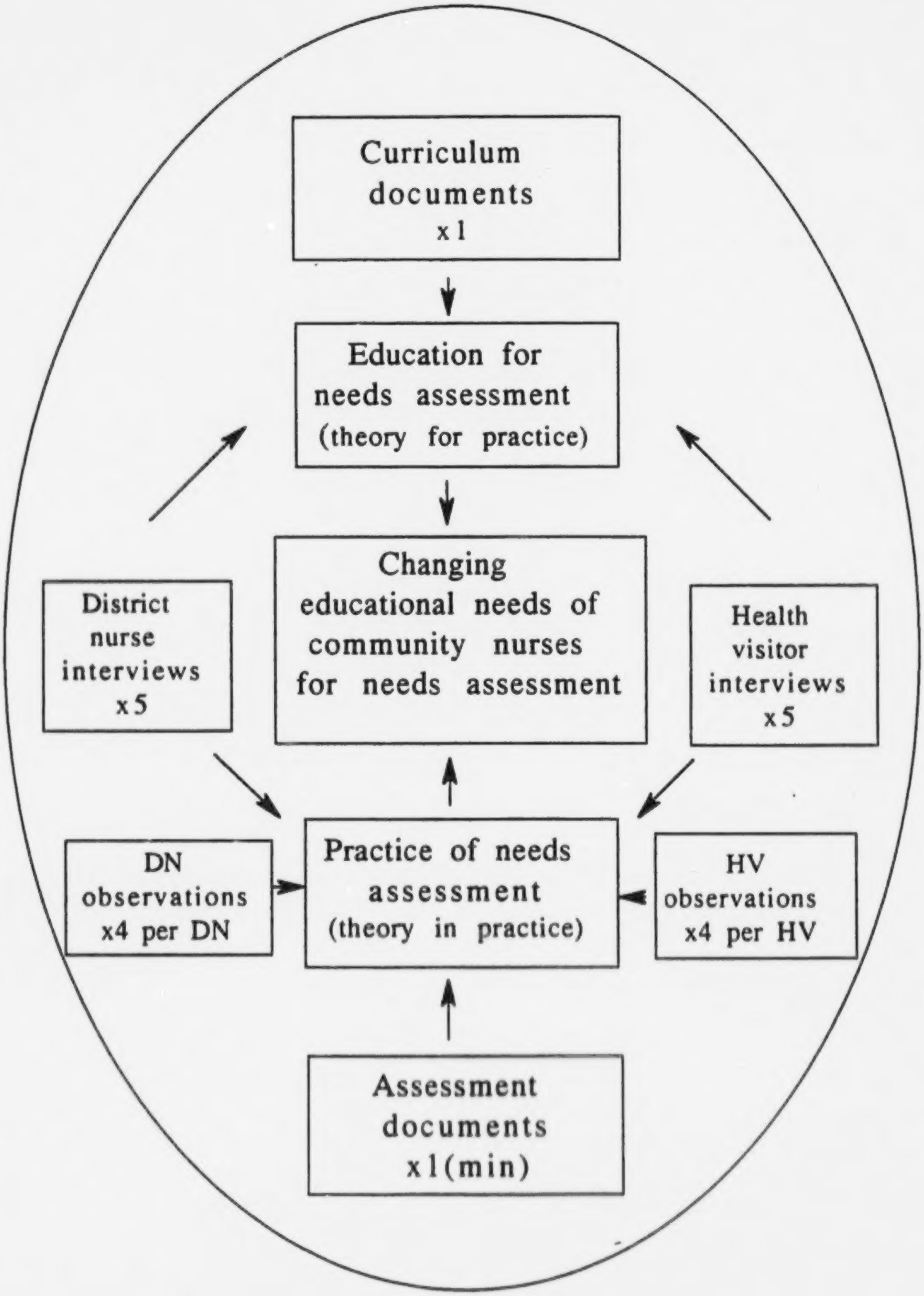
Choice of data points (that is components of the sources of evidence from where data are collected) were determined in part by the need to accomodate a detailed focus, as well as breadth, within each site and also by the nature and size of the educational courses running. This resulted in plans for five health visitors and five district nurses from each case to be interviewed once and observed doing about 4 assessment visits. It was also planned to collect accompanying documentation - assessment forms, curriculum documentation and the like (see Fig 4.2).

The original research proposal envisaged the selection of case study sites which would represent community nurse education across five of the (then existing) Regional Health Authorities, specifically chosen to reflect the geography of the health service in England. It was hoped these would represent one inner city population, one rural population, one serving the South of England, one serving Northern England and another serving the Midlands. As these were also to be represented in the final pair of focus groups (7 and 8) in phase I, contact with potential institutions had been made early on in the research programme.

Criteria for inclusion as a study site were established as follows in order to maintain the 'replicability' of the multiple case design and to avoid areas becoming 'over researched':

- site runs full-time diploma level courses of preparation for health visiting and district nursing (the timing of the study, that is, prior to implementation of PREP, made diploma, rather than degree level, the most usual and easily accessible type of course)

Fig. 4.2 Data collection protocol


Curriculum documents x1
Education for needs assessment (theory for practice)
Changing educational needs of community nurses for needs assessment
District nurse interviews x5
Health visitor interviews x5
Practice of needs assessment (theory in practice)
DN observations x4 per DN
HV observations x4 per HV
Assessment documents x1(min)

- sufficient students on each course are expected to qualify and gain appropriate employment in the current academic year. A minimum of ten students on each course was suggested, to ensure an eventual sample of five health visitors and district nurses on each site

- geographical variation and spread are ensured

- no other ENB research projects impinge on the proposed site

- participants are willing and able to take part. This included practitioners willing to be interviewed and observed, lecturers willing to participate in focus group 8 and to contact CPTs to participate on focus group 7.

An initial shortlist of five sites plus one pilot site subsequently needed to be revised when it was found they were not all able to meet the above criteria. Yin (1993) emphasizes the importance of case 'screening' in the selection of study sites and care was taken to try and identify as wide a variety of potential sites as possible. In the first instance information was collected from the ENB database, regarding the type of courses (by specialism and academic level) and number of students indexed in the current year. This information was checked by an informal enquiry of the college or university before opening any negotiation about possible access as a study site. Altogether 13 institutions, in addition to the initial six, were considered. Of these, six were immediately identified, on checking, as unsuitable, with others unwilling to commit themselves or proving difficult to access. In practice the pool of potential recruits proved limited due to changes since the creation or accessing of the database. These changes included college mergers, closure of courses, insufficient numbers on courses, courses run at the wrong academic level and failure to run both health visitor and district nursing qualifying courses.

In addition, the configuration of the 14 Regional Health Authorities had altered since the study was proposed and 'outposts' of the NHS Executive now served eight larger geographical regions of England. However, the principle of choosing sites to represent the varied geography of the health service remained and the 'new regions still served as a useful guide.

A shortlist of six sites was eventually drawn up which comprised Oxford & Anglia (pilot site), North West, North East, South Thames, South West and North Thames Health Regions. However, communication problems arose with site K following focus groups 7 and 8, due to increasing demands on lecturers, changes in management structure and the integration of colleges of nursing into higher education. Delays in acquiring the names of course participants meant contacts were established over a considerable period and the time constraints of the study called into question the viability of including the site in the study. Difficulties were discussed at a project steering group meeting, culminating in the decision to discontinue negotiations with the site. It was concluded that delays in contacting and recruiting participants, coupled with subsequent need to gain ethical and managerial approval was not possible in the given time frame. Additionally, time limitation of the study debarred the possibility of recruitment of a different study site. It was therefore agreed to continue with the remaining proposed four case study sites (L, M, N and P) plus the pilot site (O).

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5. RESEARCH CONDUCT

ACCESS TO STUDY SITES: NEGOTIATING WITH ETHICS COMMITTEES, TRUSTS AND PRACTITIONERS.

The original aim was to involve five district nurses and five health visitors in each case study site, providing a total sample of 25 district nurses and 25 health visitors. However, in practice it did not prove possible to recruit the full number of practitioners required for a number of reasons, and there was a considerable variety in the numbers obtained from the different case study sites. In a minority of cases, the potential sample exceeded the number required, while in others it was well below the anticipated number. There were two main difficulties:

- difficulties related to ethical issues and ethical approval
- difficulties related to obtaining management approval and recruiting potential sample participants.

These will be discussed below.

Ethical issues and ethical approval

Gaining ethics committee approval

Since the research involved direct contact with patients and clients, thereby involving practitioner time, approval was required from the relevant local research ethics committees for each element of data collection. Experience demonstrated that it was not usually possible to obtain consent from local trust managers for their employees to participate in the study prior to seeking ethical approval from ethics committees. However, this was sought following such approval and after the practitioners had expressed a willingness to be involved. Management agreeement was generally forthcoming in this respect.

A total of 23 applications were made (not including the pilot site) to local ethics committees over six months requesting approval to undertake the study. Where students were drawn from from a wide geographical area within a single case study site, up to seven applications were needed to cover all the trusts in which practitioners were employed on qualifying. On seven occasions approval was sought for the purpose of observing and interviewing practitioners within the trust where, in the event, only a single practitioner was involved. The average number covered by each application was two.

Problems arose at the very inception stage in that often it was impossible to identify where the individual ethics committee was located and who took responsibility for its coordination. Many of the newly formed trusts were in the process of moving into new premises and initial telephone enquiries progressed no further than a receptionist who was unaware of the existence or purpose of the ethics committee.

Some committee titles had also changed, compounding the problem and making it more difficult to identify which committee covered the new trusts. No standardization of title was found. Prefixes of ethics committees varied widely (examples included local, medical, research, joint, NHS trust, district or health authority). Initial enquiries took up to nine telephone calls before a relevant person was located, sometimes only to be informed of a new title and location at that stage.

Attempts to reduce the workload by requesting chairman's action, particularly where only one practitioner would be involved, met with no success; the full documentation was still consistently required. Eighteen of the twenty three forms received were fundamentally different from each other. The questions varied considerably, thus requiring different answers, despite being about the same study. The format of the questions was heavily dominated by experimental research design relating to medicine (ie assuming controlled clinical trials and medical intervention with patients) so many of the forms were inappropriate to the study. Additionally, the non-qualitative nature of the forms imposed restrictions on how the questions could be answered. It was quite possible to answer all the questions contained on the forms provided and still give no information about the procedures and nature of the research study. In these cases a summary sheet of the research study was included to facilitate the process of ethical approval.

In one study site individual applications were submitted to the appropriate authorities in which trusts were located. Following a waiting period of eight weeks for committees to meet it was decided to take the proposals to a newly formed lead committee which had been set up to consider all multi-centre 'trials' in the region. While this intention to 'streamline' is to be applauded it tended to reflect the medically dominated structure, format and language of application documentation and, in practice, (because it meant duplicating work) actually doubled the period of time necessary in gaining approval.

Several committees required large numbers (7-34) of copies of the completed application forms and full research proposal, with the associated reprographic costs. Attendance at the full committee hearing was required in two cases, while two others subsequently considered this request could be waived. Despite the frustrations, approval was granted in all cases and feedback was positive. Thus the labour intensive process involved in application realized a small but essential outcome in terms of the study sample.

Ethical issues

The main ethical issues to be considered concerned the potential intrusion into a private interaction between the practitioner and patient/client, and the need for fully informed consent to be obtained from participants. Practitioners were allowed plenty of time to consider if they wished to participate or not before indicating written consent. Although clients and patients were not actually the research subjects, since the observation occurred in their homes, their consent was required for the researcher to enter and be present during the community nursing procedure.

The issue of verbal versus written consent requirements from patients/clients proved problematical. At the request of one ethics committee during pilot work, signed consent was obtained from clients. However, the process of obtaining this consent had the potential to be more intrusive and anxiety-provoking than the actual observation. It necessitated the recording of personal information not otherwise required for the research. Further, it drew attention to the presence of the researcher at the outset of the observation, when an unobtrusive stance was particularly required. Concern about obtaining this consent led one potential participant to withdraw from the study.

Since the pilot study the positon of the practitioner, rather than the patient/client, as research subject was stressed on application forms and most ethics committees subsequently accepted that verbal consent would suffice. According to the protocol, verbal explanation was offered and agreement sought from the clients/patients for the researcher to enter the home. This was regarded as sufficient, though an information sheet was left in the home, should the individual subsequently desire further particulars of the study.

For purposes of courtesy and to avoid potential confusion, district nurses and health visitors were provided with information sheets to forward to general practitioners of clients/patients involved. This approach appeared to be acceptable to all.

Gaining ethical approval in nursing research: some reflections

There is evidence that the difficulties experienced in the current research are not unique. Diversity in practice noted in the late 1980s (Gilbert et al, 1989) prompted the publication of guidelines by the Department of Health on local research ethics committees (DoH, 1991). However, problems appear to remain which may particularly disadvantage research of the kind being currently undertaken.

Albert (1995), commenting on recent papers published in the British Medical Journal, noted that studies involving questionnaires and/or interviews, rather than physically invasive procedures - requiring what he termed 'social protocols' - seem to create the biggest uncertainty for ethics committees. This may militate disproportionately against the approval of nursing research, which often favours this type of data collection method. Indeed, such problems in coping with medically dominated committees have recently been documented by nurses (While, 1995, Sapsed, 1996).

In addition, the lack of a common application form, also noted by Albert (1995) may have particular repercussions in multi-centre and multi-site research, where multiple applications to committees need to be processed. Both the Kings's Fund (Neuberger, 1992) and a recent report by the NHS Research and Development Task Force (DoH 1994a) have commented on the time consuming nature of this. Again, this is likely to be a feature of much nursing research, particularly when centrally commissioned, and, again, it can be illustrated; While (1995), in a Department of Health funded multi-centre nursing study, sought approval from 43 DHA ethics committees, which took between 6 and 161 days to notify the researcher of the outcome. The author supports recommendations elsewhere for the establishment of a national ethics committee for such multi-centre studies. The experiences of the present research would also support this recommendation.

Management approval and gaining access

Gaining management consent

Consent was also sought from 23 NHS community trusts in the four regions where the case study sites were located. Negotiations were undertaken during a period of immense change and management reorganisation. Up to three levels of management had to be contacted in some newly formed trusts in order to gain approval for the involvement of their employees.

The process to some degree mirrored the experience of ethical approval in that trusts had been re-formed, renamed, and re-located. Management personnel were completely replaced in some trusts requiring re-negotiation with other managers charged with new roles and new titles. Two of the trusts were in dispute with their district nursing staff over grading, contracts and practice issues. Managers were often initially guarded about the research, and negotiations required sensitivity until they were fully informed about the aims and methods of the study. Initial communication was undertaken by telephone and immediately followed by written details in fax and mail.

Outcomes of the negotiations with the managers were generally extremely positive. Indeed there was a great interest in the impact of needs assessment on community practitioners and in how future educational preparation will address the changing needs of their employees. Both practitioners and trust managers expressed interest in how the findings of the study would be communicated to them.

Accessing participants

Gaining access to the qualifying practitioners varied in different case study sites. Three sites enabled direct access to the qualifying practitioners by providing computer lists of their names, addresses, seconding trusts and employment status where known. These potential participants were mailed an information package with a cover letter seeking their involvement and stressing the value of their proposed contribution to planning future educational programmes in community nursing. A summary of the study, and details of what their involvement would entail were also included. The aim was to afford potential participants unpressurized time to learn about the study and to consider involvement. Those volunteering to participate were asked to complete the standard form enclosed in the information pack, indicating their willingness for this. This was vital since, often, only on receipt of indication of participants' willingness, could application to the local ethics committee (and therefore managerial permission to continue) proceed. Dovetailing these procedures inevitably proved challenging.

University policies for maintaining the confidentiality of their students in the remaining two sites prevented the research team contacting potential participants directly. In those cases, the information packages were sent to the course coordinators for distribution to the qualifying practitioners. Where possible, lecturers were asked to introduce the details of the study to their students prior to inviting them to participate. This became a difficult task because the timing of the request coincided with the dispersal of practitioners into supervised practice. In some cases where information was given by the university a degree of misinformation occurred among potential participants.

There appears to be a correlation between response rate and how the initial introduction to the study was undertaken. Where individual lecturers had the opportunity to discuss the study with the group of qualifiers prior to their receiving written information, this appears to have increased the willingness and interest of potential participants. On reflection a more interactive approach between the research team and the cohort of students at each study site may have produced a larger sample. Additionally, this would have served as a communication strategy in promoting research awareness among community practitioners and educationalists. Unfortunately this proved impossible due to the limited time commissioned for the study and the incongruence between the academic year and the timing of the research contract.

A conscious effort was made to word correspondence in a friendly way and response slips and stamped addressed envelopes were provided. Despite this, there were a number of refusals and failures to respond. Those who declined to be involved did not always offer a reason and of those who did, reasons given were primarily centred around employment difficulties, the stresses of settling into a new role, not wanting to be observed and concern about seeking written consent from clients (as discussed above, this was requested by one ethics committee).

Employment difficulties were particularly problematical. Initially, it was planned to recruit practitioners drawn from the 1993/94 cohort in full employment on a 'G' grade post with full caseload responsibilities. These criteria were not achievable given the changing nature of employment within community nursing at the time. The potential sample appeared to be experiencing trends reported elsewhere (Durdle, 1995) of difficulty in obtaining work following skill mix reviews (especially in district nursing) of reducing grades, increasing part-time work and use of short term contracts. Others were not working in the field of their new qualification. On a more positive note, other potential participants reported full time 'G' grade contracts with full case load responsibilities following skill mix reviews, which had upgraded, rather than reduced, their positon.

For some sections of the participants, computerized information supplied was found to be out of date due to the time lapse since compilation. Subsequently, selection of the sample was influenced by those individuals who failed to qualify or gain employment, who took extended holidays, who moved away, moved house or changed marital status or name. Pregnancy and illness were additional confounding circumstances. Recruitment of the final sample was slow and patchy and required constant monitoring to maintain interest. The final figures are shown below, followed by an account of individual case details:

Summary of sample accessed in the study sites

(DN = district nurses, HV = health visitors)

Site	Cohort size	Number contacted	Number agreeing	Final sample	Trusts accessed	Ethics committees
L	11DN 23HV	11DN 20HV	5DN 6HV	4DN 5HV	7	7
M	9DN 27HV	3DN 26HV	3DN 10HV	2DN 6HV	8	8
N	21DN 16HV	21DN 16HV	4DN 5HV	4DN 4HV	4	4
P	10DN 11HV	5DN 7HV	5DN 7HV	4DN 4HV	4	4
Total	51DN 77HV	40DN 69HV	17DN 28HV	14DN 19HV	23	23

Case study site L

Lecturers were unable to inform the students about the study before moving out into practice. Once lists of qualifying practitioners were obtained, standard invitation, information, and self selection forms were mailed to individuals. A second mail shot was undertaken following a slow response from district nurses. An improved sample of 4 was achieved following a 'snowball' effect during data collection. An extended data collection time was arranged to include one participant who became ill. Multiple factors appeared to have influenced the practitioners' reluctance to participate. Some practitioners had moved away, changed trusts and experienced difficulties in obtaining appropriate posts or settling into their new role

The issues of observing the assessment of need in clients whose first language was not English was addressed by two of the ethics committees, who required evidence of how this would be managed by the research team. Despite the number of ethics committees approached, there were no significant difficulties individually but collectively they were time consuming.

Access to curriculum documentation was problematic due to the course leader's illness, necessitating alternative arrangements. Documentary analysis was felt to be essential to the use of multiple sources of evidence in case study research.

Case study site M

Gaining access to potential participants involved a combination of approaches here. Lecturers explained the study to district nursing students, and willing participants completed the self selection forms provided by the research team. Health visitor qualifiers were not contacted by the lecturer due to the numbers involved and their dispersal into practice. A computerised list was obtained and the standard procedure of mailing invitation pack and follow up letter occurred. Positive responses trickled in over a period of 6 weeks. Pregnancy, illness, and the withdrawal of one participant from the study impacted on the data collection period.

The small sample of district nurse participants was drawn from the smallest student cohort compared to the other three Universities. Employing and purchasing trusts (mainly newly-formed community health care trusts) displayed a wide variation and inequality in how the small sample of district nurse participants were graded on completion of the course. Newly qualified practitioners found the inequality divisive when compared to the consistency of 'G' grades being offered the health visitors on qualification.

Applications to the largest number of ethical committees raised no ethical issues. Individual applications were processed in a relatively short period. One ethics committee suggested that a study exclusively into professionals education and training needs required no ethical approval. Ethical approval was required only if 'anything is being done to the patients'.

Case study site N

Despite early contact with the research team, lecturers were unable to inform the students about the study prior to moving out into practice. Computerised lists of qualifying practitioners were obained. Standard invitation, information and self completing form were mailed to them. A slow response yeilded a sample of one health visitor, thus a second mail shot was undertaken without effect. Initially the recruited sample remained small until data collection began. Once trust had been established with participants who completed the observation and interview they felt willing to suggest the study to their colleagues from the same cohort. This process of 'snowball sampling' (Morse 1991) helped to realise the sample of 4 finally achieved. Address changes, two pregnancies, and the settling down into employment following the course appears to have contributed to the slow response.

Ethical approval, despite the small number of applications, took five months.

Case study site P

University policy safeguarding student confidentiality prevented direct access by researchers to potential participants at this site. Lecturers introduced the study to their students and mailed the information package provided by the research team. Response was rapid when compared to the other sites as self completed forms were returned within two weeks. Participants were contacted by the research team to discuss their role in the study and confirm their eligibility. Some potential participants were unable to acquire posts appropriate to their new qualification. Two willing practitioners became ineligible due to having to take up employment not requiring their newly obtained qualification.

DATA COLLECTION

The data collection phase commenced in early April following the refinement of the research instrument during the pilot study (see previous chapter). Participants were prepared by ensuring receipt of clear information about the study and an outline of how the observations and interviews would be carried out.

Each researcher took major responsibility for one case study site, collecting data from practitioners of their own professional orientation. The research assistant, with a dual qualification, collected data from the remaining (health visitor or district nurse) participants in each site, in addition to her own. Although this precluded testing for inter-rater reliability (since there was no cross-specialization involvement) it did allow for some continuity across sites.

Practitioners were observed during one morning undertaking about four home visits with patients/clients. Where possible a primary or first time visit was included in the observations. This was followed in the afternoon by a tape recorded interview to elicit the practitioners' views of needs assessment and their educational preparation for needs assessment.

Consent to observe practitioners visiting the clients in their own homes was gained by participants in agreeing appointment times, and again on the morning of the visits. A standard information sheet about the study was given to clients and participants reiterating the confidentiality of the data.

Time involved in travelling between visits provided the participants with the opportunity to talk more freely and naturally. Visits undertaken were 'summed up' and information was collected about the next visit. Valuable insights into how practitioners go about their work, making judgements and decisions were collected as field notes.

Many participants reported feeling stressed in anticipating being observed and the researchers were aware of the risk of 'reactivity' (Sapford and Abbott, 1992) in that researcher presence may alter the situation. However, once the observations began the researchers tended to merge into the background and did not significantly intrude upon the interactions between practitioners and clients.

The period between the observations and interview afforded some respite for the practitioners and time for the researchers to identify issues from the observations which required clarification or further development.

The guided interviews (Field and Morse, 1990) were undertaken in a manner which would reduce the 'asymmetry of power' and the 'de-contextualising features' found in traditional interviewing (Mishler, 1986). Interviews with participants were tape recorded and lasted 60 - 90 minutes. Despite prior preparation some difficulties were encountered with time constraints and interruptions as well as tape recorder, tape, and microphone faults, resulting in a reduction or loss of parts of the data.

A degree of catharsis occurred with some of the participants during the interview. The interview encounter appeared to have enabled them the freedom to explore, reflect, and to share their frustrations, beliefs and aspirations in making sense of their educational experience. Thus it was felt necessary to spend a variable period of time with the participants following the interview. This could be considered a debriefing exercise following an intense and stressful day. It was found to be of value to the participants and the researchers and needed to be built into researchers' travel schedules.

Since case study inquiries rely upon the multiple sources of evidence in converging the data and strengthening the construct validity (Yin, 1994) available educational and trust documents were also collected. Course documents from the universities involved were also sought for analysis.

DATA ANALYSIS AND ISSUES OF RELIABILITY AND VALIDITY

Yin (1994) comments that the analysis of case study evidence is one of the least developed and most difficult aspects of doing case studies. To facilitate this, Yin stresses the importance of having a good analytic strategy in order to "help an investigation to choose among different techniques and to complete the analytic phase of the research successfully" (Yin, 1994 p.103). In view of this, discussion regarding specific analytic strategies began at the time the instrument development was finalized, and continued throughout data collection, when it was refined.

In Yin's conceptualization (Fig. 5.1) each individual case study consists of a 'whole' study for analytic purposes, with each case's conclusions then being considered to be the information needing replication by other individual cases within the replication logic. Thus the question of external validity (as outlined above) was addressed as Yin (1994) suggests, by treating cases and data points within them not as components of a representative sample, amenable to statistical generalization, but rather as the basis of theory development, which is amenable to analytical generalization. Both individual cases and the multiple case results are then the focus of a summary report.

In order to reinforce this analytic logic, each researcher took responsibility for the analysis of a single case. Although this had the potential to dilute consistency (that is, reliability) this was felt to be more than offset by the strengths of ensuring the danger of 'pooling' across cases (which Yin, 1993, warns against) was minimized. Indeed, each researcher was able to call upon her own strengths and experiences in order to ensure each particular case was treated in a way which would enhance internal consistency. At the crucial stage of cross case analysis, where findings related to individual cases were compared, the existence of literal or theoretical replication (findings 'predicted' as similar or different on the basis of existing theory) would be more powerful for having emerged from totally separate analyses.

Yin offers two general analytic strategies for consideration by case study researchers, the 'preferred' of which, relying on theoretical propositions, was originally planned for the present research. Yin's definition of a proposition, noted above, as "theory which directs attention to something that should be examined within the scope of the study" allowed the researchers to use both literature and focus group data to this end. For interview analysis a framework was derived from these data where issues of a recurrent nature were subsumed within nine propositional statements into which interview excerpts could be placed as either supportive or refutable evidence. A tenth category was created where 'non classifiable' data could be held.

However, the 'propositional' nature of the statements proved difficult to sustain on testing and an alternative was sought. A second, more inductive, approach consisted of an initial overview of data representing all sites and researchers, which yielded a number of recurrent themes. From an amalgamation of these two methods emerged a framework which appeared to both accommodate the data set and structure it appropriately around the research aim; thus categories were developed which did not have the constraints of requiring evidence supporting or refuting a statement (Appendix 4) Interview data examples from each case were tabulated where possible under the appropriate headings, with data source and location recorded for ease of reference. Where the nature of the data did not immediately lend itself to this breakdown (cases M and N) different (but not dissimilar) categories were developed. (Appendix 5).

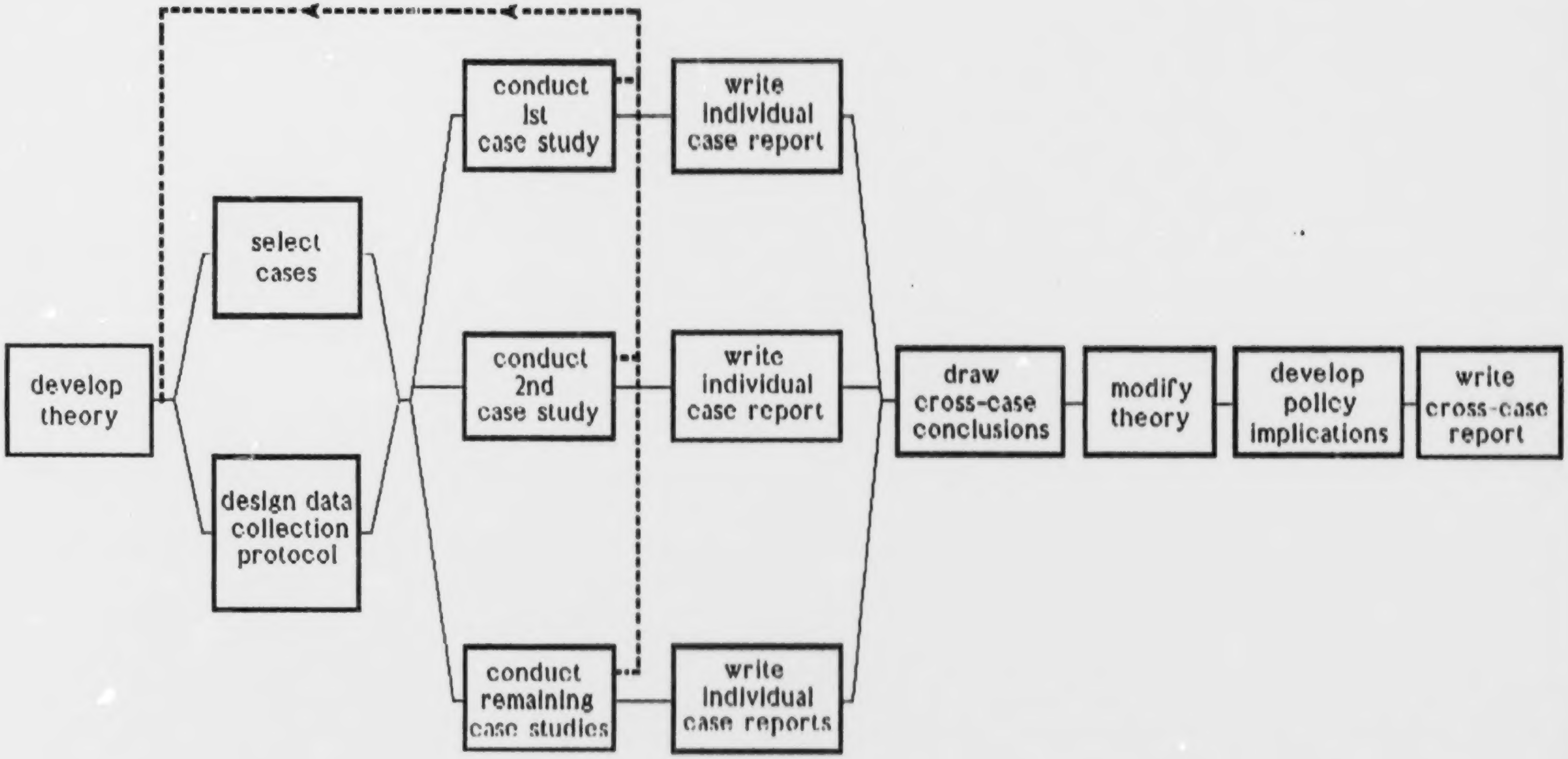
develop theory
select cases
design data collection protocol
conduct 1st case study
conduct 2nd case study
conduct remaining case studies
write individual case report
write individual case report
write individual case reports
draw cross-case conclusions
modify theory
develop policy implications
write cross-case report

Fig 5.1 Multiple case study method

After Yin (1994)

At the same time, consideration was given to the feasibility of analyzing 'indexed assessments' - ie the observed visit upon which the interview particularly focussed - as separate episodes, through the use of the Critical Incident Technique (Flanagan, 1954, Norman et al, 1992). However, after some discussion, it was felt that this framework may not fully exploit the potential of either the data or the method and an alternative, less constraining, usage was established in their use as 'embedded units' (Yin, 1994) within each case's tabulated data.

The observation data were collated through the use of Minitab (computer software which aids statistical analysis), allowing summarization and simple cross tabulation of quantitative data and facilitating easier reference to qualitative data (ie observer comments) where necessary. The value of this became apparent when observations were analyzed alongside findings from interview data.

Relevant observation data, along with documentary data examples, served to supplement the condensed tabulated data. Such use of multiple sources of evidence served, as previously suggested, to enhance construct validity. This was also supplemented by a summary of the findings related to that category and a general commentary. In order not to lose sight of the educational dimension, a statement of educational implications was also included (see chapter 6).

In terms of specific analytic techniques within the general analytic strategy, it was originally planed to use the principles of 'pattern matching', one of Yin's 'dominant modes of analysis' which "compares an empirically based pattern with a predicted one..." (Yin, 1994, p.106). It was envisaged that this could be linked to the emerging theory (Yin's 'propositions') and facilitate the cross case analysis, allowing findings to be 'matched' against the findings of all four cases with regard to both practice and education (Fig. 5.2).

However, this, too, proved problematical in its outworking, since it was not clear what would constitute a good 'match' in terms of data illustrations, and the construction of comprehensive operational definitions could be unwieldy and time consuming. Instead, it was decided to adapt the second of Yin's two dominant modes of analysis, that of explanation building, analogous in many ways to pattern matching, but aimed instead at 'explaining' a phenomenon, with explanations reflecting some of the significant 'propositions' (theory). This is in keeping with Yin's (1994) recommended strategy for enhancing internal validity.

A model encompassing such explanatory potential was found in the work of Parasuraman et al (1985), which aims to measure service quality through a series of 'gaps' which may occur anywhere in the chain between consumer expectation and actual service delivery. This would also meet two other needs of the research. Firstly, it would address the 'quality of care' issue, which constituted one of the research aims. Secondly, it could accomodate the parallel foci within the research of practice of, and education for, needs assessment. In addition, its cyclical conceptualization reflects the "iterative nature of explanation building" stressed by Yin (1994, p.111). Used as an overarching framework at the cross case level, this proved a workable, if challenging, framework for the research team (for a fuller discussion see Chapter 7).

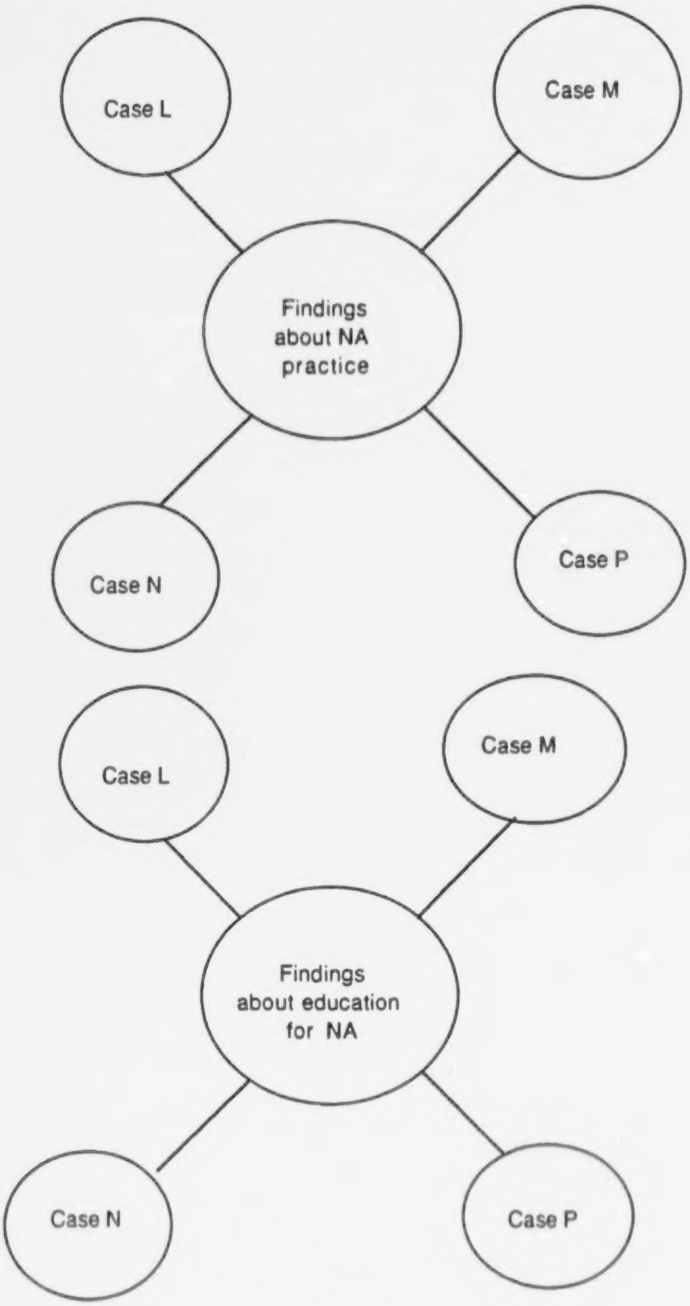
Case L
Case M
Findings about NA practice
Case N
Case P
Case L
Case M
Findings about education for NA
Case N
Case P

Fig. 5.2 Cross case pattern matching

6. FINDINGS FROM INDIVIDUAL CASE STUDY SITES

Introduction.

This chapter of the report will outline the findings from each of the individual case study sites sequentially to provide the setting for the cross case study analysis in the next section. Before doing so, some general information which forms the background to the findings, will be presented.

Background information.

The recruitment of newly qualified district nurses and health visitors to the study from each of the case study sites was influenced by several different factors. These were mostly related to 2 broad issues: the changing context of nursing education within the university sector, and the organisational changes being made by NHS Trusts following the NHS and Community Care reforms. Although these might be considered sampling issues, they are also important contextual information for current educational and clinical practice. As they are in themselves part of the evolving situation, they are presented as background findings.

During phase two of the study, the research team found that access to educationists (and therefore to the sample) was restricted during the time of recruitment (so much so that one case study site had to be withdrawn from the research). This seemed to be connected to workload pressure which resulted from organisational and curriculae changes which followed new policy. During the research study, nursing education for community nurses was influenced by two separate types of policy. Firstly, policy guidance for educationists (from the English National Board and UKCC) regarding educational and academic standards, as well as the proposals for post registration education for practice; and secondly by the changing climate of university funding, organisation and education practice. It seems important that this context is recognised as the findings for this research study are presented.

In a similar way, newly qualified practitioners were affected by the reforms of the health service. The reforms influenced their employment prospects, evidenced by the lack of vacant positions in community nursing and also the lower grades of posts for which they were able to apply. This was especially pronounced for the district nursing practitioners in each of our case study sites, and although present, was less obvious for health visitors. This reduced our ability to recruit participants to the study, and original criteria for selection to the study had to be relaxed so that pracitioners without 'G' grade positions were included. All practitioners had registered community nursing qualifications as district nurses or health visitors, but a variety of different grades of practitioners were observed and interviewed, ranging from D grades to G grades. Despite our attempts to reassure potential participants, individual discussions during the recruitment process made it clear that several practitioners who had acquired lower grade posts were reluctant (or refused) to take part in the study. Those who did not take part in the study for reasons of grading were concerned that their job descriptions (and the assessment practice they allowed) did not adequately reflect their level of expertise as learned during their community nursing course. The research team acknowledge that despite efforts to the contrary, the grading issue potentially introduces an unknown element of bias in the recruiting and data collection for phase two of the study, although it is thought that this was minimal.

Responsibilities for analysis of case study sites.

Prior to data analysis, the research team discussed the framework and format of analysis, and decised about broad methods for standardising the way in which the data was analysed. During the analytic process, there was cross referral and discussion between the researchers who collected data within case study sites, but no cross-case study site referral, to avoid contaminating the integrity of the individual case study site findings. Each case study site was analysed by one of the researchers, in consultation with the research assistant, such that the member of the research team with major responsibility for the case study site analysed the full data set from this individual case study site. For these reasons, there are small variations in the way that the data are presented, but this can be seen as a strength to the research design, in that it increases the external validity of the cross case analysis (i.e. the themes and patterns appearing repeatedly across case study sites have better external validity).

The remainder of this section will be divided into the four case study sites, so that information about each of the case study sites is presented, and then followed by a summary of the findings.

CASE 'L'.

The educational institution which formed case 'L' was situated in a densely populated, inner city area. It has a long history of running community nursing courses, and the health visiting and district nursing courses were validated by the ENB at diploma level immediately prior to our sample enrolling on the course. The university itself has undergone significant changes in the last 5 years, with major organisational and cultural shifts. The staff who contribute to the community nursing course have a variety of different professional and academic qualifications, varying from a few who are educated to PhD level to those who are currently studying part-time for their first degree, and from those with significant professional experience to those with none.

Students are taught core courses with other types of community nurses, but have professional courses for their own disciplines. After qualifying, participants were largely employed in Trusts which served densely populated areas containing strongly contrasting socio-cultural groups. Two ethics committees raised issues concerning the research study design and its ability to engage in meaningful data collection for those whose first language was not English, but were satisfied with full explanations to them of the procedures to be followed in these cases.

There were a number of problems in gaining access to the district nursing sample due to illness or problems obtaining posts appropriate to qualifying, but this was overcome by gradual participation in the study by 'snowballing' (Morse, 1991). The following table shows the numerical information pertinent to the sampling process:

CASE L	District Nurses:	Health Visitors:
Cohort size	11	23
Number contacted by researchers	11	20
Number agreeing to take part	5	6
Final Sample	4	4
Number of Trusts	7	
Number of Ethics Committees	7	

The findings from the observation, interview and curriculae from case 'L' will now be presented in tabular form, according to the themes derived from the framework used in analysis.

Category: Need	**Case Study Site:** L
Data Examples	**Findings emerging from the data**
Interview themes (see Appendix 6L1) Need as Subjective (all practitioners) Need as context bound (all practitioners) Need as variable & changeable (all DNs, HV1) Need as hidden, barely visible Need as holistic, Need as an interplay between components of health.	There was universal recognition that need is subjective, with particular concentration on the DN/HV interface with the client & family. Need was only talked about as objective where perceptions of need varied (ie from prof-pt , or if service defined need differently from HV/DN). Less frequently mentioned were prof vs prof definition of need & different agency definitions. There was recognifion that definition of need changed with philosophy used (ie measures of poverty DN2, Models DN3, generally DN4).
Observation data Almost all practitioners recognised the clients view of need, apart from 4 instances, all from HVs. Most practitioners discussed the service definition of need, and in all but 5 of these cases the client & service agreed about need. The vast majority (31) discussed their judgement re: need with the client, with slightly less (29) allowing client to feed into definition of need. 60% assessments appeared to contain an effort by the practitioners to discover hidden needs, although this might be influenced by the fact that only 8 visits (20%) were first assessments. 60% assessments showed that practitioners recognised wider effects of need, mostly concentrating on the client and family, although 6 visits mentioned the social context of need. Knowledge which drawn on was mainly biological, developmental (Paed DN, HVs), and pathology (all DNs), although DNs referred to pharmacology, sociology linked information and 3 DNs referred to political influences on health care. Clients used knowledge less frequently, but pharmacology, pathology, biology were referred to by a few, and surprisingly, 15 clients referred specifically to levels/types of service provision available to them.	Needs were universally seen as being bound by context, most frequently by social & socio-economic circumstances of pt, although some recognition of service led definitions contextually defining need. Where needs were stated particularly as not bound by context (HV1&2) this referred specifically to the presence of need in the absence of service. Need was seen as changeable both in the short & long term, according to pt condition, pt attitude to condition, pt attitudes to prof ways of working, pt knowledge, context, changes in prof. defn. of need, and this was talked about more commonly as deterioration than improvement. Only one DN saw need as static in that she was talking about a child's normal routine. Need was seen as hidden & barely visible by 3 DNs & HV1, they were sometimes talking about hidden pt needs, and sometimes about hidden nursing (eg psychological support). In some cases DN2&3 it was seen as hidden with some quantifiable elements, eg elder abuse
Documentation Data The curriculum mentioned need only in the broadest of terms, but recognised that DN/HV practice should be orientated to meet needs. The DN course described the holistic nature of needs, whereas the HVing course emphasised a proactive search for needs at all levels and recognised needs as subjective and therefore meeting them problematic, especially with current resource constraints.	Need was specifically mentioned as holistic by DN1, HV1,HV2, & HV3, and all HVs saw need as an interplay between components of health, as did DN2 & DN4. HV 1 & HV2 saw need as "ever present", with DN2 felt that it was not always possible to address need directly.

Commentary	Educational Implications
An awareness of the dual nature of need was demonstrated only in part. The objectivity of need was not articulated particularly well, or the ability to measure need & to record it, perhaps because this is "given" & causes less anxiety in practice. Differences in perception of need were discussed both in the abstract and in reference to particular pts, and this may be due to the dilemmas that this causes (& attendant anxiety) in new practitioners , or to the exercise of finely balanced professional judgement.	Dealing with the demands placed upon practitioners by subjectivity and contextual nature of need should play a part in the curriculum & practice component (ie assertiveness training, stress management, clinical supervision).

Category: Needs assessment overview	**Case Study Site**: L
Data Examples	**Findings emerging from the data**
Interview themes (see Appendix 6L2) Needs Assessment as ongoing process Needs assessment as structured Profesionally owned Health & social needs Ideal vs Reality Specialist / General / Core community NA Outcomes Assessment for What ?	All DNs saw needs assessment as ongoing, although DN4 acknowledged that she tried to do as much as is possible on first visit as she didn't always know when she would be able to return. Only one HV (3) specifically identified assessment as ongoing, HV 1 & 2 equates addressing needs with needs assessment, and could only talk of needs assessment as care / support given. DN1 saw NA as a single event when it was made in the form of a joint visit. There was different usage of the term structured / unstructured, but all practitioners seemed to describe a process which was mixed, attempting to structure their questions by theory or an agenda, but making it flexible and friendly informal in approach. All practitioners could see their professional contribution to NA, some identified particular areas such as wound care. There was evidence of multi-assessments still existing for patients, and DN3 cited one situation where SS led assessment had proved inappropriate for pt care by DNs (medication). All practitioners believed that they had to assess health and social aspects of need, but DNs recognise that limits exist to their involvement in care. Here preliminary assessment may lead to referral rather than care. HV1 doesn't seem to make any distinction, whereas HV2 sees health & social needs assessment as totally separate, whilst believing that social needs are more subjective.
Observation data **Average length of assessment: DN =29; HV39; overall 34 mins.** In practice (observed) none of the practitioners seemed to rely greatly on the assessment forms in use in their Trusts. The vast majority of clients were not reluctant to discuss aspects of need with practitioners, the 4 who were were 1DN & 3HV clients, and this was acknowledged by 2 of the practitioners. During 8 assessments, DNs refused to discuss, blocked or avoided subjects which the client raised, only 3 of these showed an awareness of the client's wish to discuss topic, and this was by referring to a time in the future when they would address it.	All DNs and HV1&2 discussed the less than ideal resources. Dn2,3,4, & HV1 discussed different perceptions of need as being less than ideal, leading to quibbling between HS / SS, strain in pt-Dn relations, feeling that should be doing more associated with not being equipped to deal (either int ime, facilities or in expertise) with the need arising. Hv2&3 discussed CHRs as problematic, as not comprehensive assessment of need in family or child.
Documentation Data There was too little detail in the curriculum to be sure of the extent that this was covered. DN course curriculum focussed on needs assessment by use of models and how to use assessment forms. The health visiting course discussed the political nature of needs assessment, but the course reference material did not appear to reflect this.	There was very mixed evidence of specialist / general nursing or core community needs assessment, perhaps indicating a state of flux. The outcomes discussed were various, with no clear themes emerging. All practitioners emphasised that assessment was for monitoring pts / clients conditions / progress. Most practitioners said they assessed to see whether further investigation / referral was required (all except HV3. DN1& 2 HV2 & 3 said they assessed so that they could address need, whilst DN3&4 HV1&2 discussed better QOL & QOC as a natural thing to ensuefrom NA. There was weak evidence that this was sometimes done to address the concerns of CSNs (DN4) and also to encourage the use of facilities (HV1).

Commentary	Educational Implications
The data contained in this category seems to indicate the complexity of the topic. Generally, practitioners do not see needs assessment as defined in the NHS & CC Act, it is seen as a part of an ongoing process, which is used to monitor clients' condition / progress. There was one instant where NA was seen as a single event and this was for joint assessment. The problems with this model for H & SS are discussed under joint working, with the bureaucratic process making change according pts condition difficult. None of the practitioners were able to discuss the Act in great detail, or relate it fully to practice issues, and this must be in part because of their poor educational experience as described by them.	Assessment may run throughout the curriculum (?), but this may mean that students find it difficult to comprehensively integrate such a large amount of diverse material into their thinking. Alternatively, it is not covered in sufficient depth to be useful to practitioners in their practice, or to be able to articulate any underlying theory of assessment well in interview. The complexity of the subject may however lead to this anyway (Cowley et al, 1996) There was some indication that students would have liked more direct teaching around the subject, although the research itself could have provoked such thought. The professional implications of being unable to link practice to Social Policy are worrying

Category: Individual & family needs assessment	**Case Study Site**: L
Data Examples	**Findings emerging from the data**
Interview themes (see Appendix 6L3) Family as context. Family as carers Conflicts of interest between carer and patint (*missed opportunities for care seem to exist where perceptions of need do not agree)* Communication skills vs. technical measurement skills.	All practitioners incorporated the family in their approach to NA, even absent family members (DN2&3) The family resources were a contextual factor in assessing & addressing need, with all practitioners except HV2 saying that they actively encourage care by the family. All practitioners recognised that family members have needs too, which can make them a subject for assessment & care in their own right. The family as a unit was commonly discussed with reference to the strength of relationships, with DN1&2 indicating that the family has a legitimate need to maintain privacy / contain issues within it, without unnecessary interference from professionals. Conflicts of interest between pt & family were discussed by all practitioners, as affecting their ability to assess & address need. HV3 talked of the difficulty of recording these conflicts adequately on a CHR.
Observation data 60% practitioners explicitly referred to the wider context of needs in terms of the family.	Practitioners all talked in some detail about the myriad communication skills used to elicit the diversity of human response, whereas they did not talk at all about specific skills to measure & record indicators of need. Knowledge underlying the care they talked of included psychology, biology, pathology, pharmacology and developmental. Negative examples / missed opportunities was only discussed by 3 practitioners DN3,4,HV3) & mainly centred on different perceptions of need (Family, pt, service, professionals).
Documentation Data This was incorporated into both DN and HV course content, although the curriculum is not detailed enough to provide information on what is covered when addressing this topic.	

Commentary	Educational Implications
The family is a central element in assessment of need, and varied perceptions of need come into play here. Practitioners did relate this to their training, both pre-and post- registration.	Practitioners seemed well able to discuss the detailed affects family has on need. This is a success for education !! Practitioners seemed to discuss care by the family as a good thing, and be limited only by practical or emotional constraints to caring by family. The philosophical arguements for and against this were not discussed. Does this indicate that care by the family is so accepted (even in professional circles) that practitioners act as agents of the state and do not challenge this assumption, or where they do, are not able to justify why given the current policy climate? Ethical principles guiding practice in such dilemmas may need to be emphasised more in courses.

Category: Collective needs assessment	**Case Study Site**: L
Data Examples	**Findings emerging from the data**
Interview themes (see Appendix 6L4) Compilation & analysis of health needs data in profile Intuitive profiles dominant mode of working Management Issues Referral for care Vs search for health needs.	Four practitioners identified this as a formal activity in their student course, 1 (HV2) in practice. There was ample evidence that practitioners held profiles of their caseload, but this was largely intuitive with some attempts at case counts (DN3, HV3). The only full profile of a caseload was made at the request of management. Two practitioners saw the danger of this approach, one because of dynamic nature of locality making it difficult for individual practitioners to keep up with change, and the other recognised that clients she saw may not be the ones in most need (DN3). Only 1 practitioner saw the wider purpose of individual NA (DN2), who, if need occurred frequently would go and discuss it with her manager.
Observation data None relevant.	DNs 2&3 & all HVs saw the use of profiles of community (& own activity) as being of use to management, for planning provision, to justify provision, to contextualise need and to ensure efective QOC "seeing the right people". There was some evidence that decisions based on the statistics provided were not fed back to practitioners which was a source of regret.
Documentation Data Both the DN and HV course required profiles to be drawn up in student practice setting. This was not purely intuitive, and the use of this type of profiling was not mentioned in the curriculum. Both the DN and HV course discussed caseload management.	DN3 pointed out that profiling itself is fine, but since DNs only get pts through referral not a search for health needs, there was a gap between reality & rhetoric.

Commentary	Educational Implications
Is the wide use of intuitive profiling largely because management do not allow time for / recognise the value of this part of practitioners work ? Or is it because students have no role models for this in the practice setting? Or because they are learning the daily coping strategies when still newly qualified and this is perceived as being less necessary for daily survival ? Or is it seen as being sufficient or better than formal profiles ?	The advantages and disadvantages of intuitive profiling should be discussed in educational programmes, alongside their use in a less than ideal setting. It is of particular interest that no practitioners referred to use of data contained in the Public Health report or the Community Care Plan, which are an immediate indication of the need in their surrounding area. This may be due to inadequate preparation for practice or a lack of availability / perceived relevance. The point made by DN3 is of interest, and should be discussed more openly in educational programmes

Category: Working & sharing with clients	**Case Study Site**: L
Data Examples	**Findings emerging from the data**
Interview themes (see Appendix 6L5) Client led Assessment: seeking their views Advocating for clients Client held records Theory vs Reality	All practitioners demonstrated seeking the views of clients and discussed this as an integral part of their work. There were strong links that this was done to promote care by the family / pt. It was also used as a mode of working to marry up client & professional views of need - giving background information so that clients could "work it out" or "try this & see what you think". There was weak evidence that pts view of need does not always equal service definition and practitioners exhibited client led (most commonly advocating for clients with SS) & service led response (do nothing). Honesty with clients was discussed, particularly where perceptions of need were different (DN2&3 HV 1). Only 1 practitioner said that this was included in their mission statement.
Observation data All but 4 practitioners recognised client views of need. The vast majority (31) practitioners discussed their judgement re: need with the client, with slightly less (29) allowing client to feed into definition of need.	Client held records were discussed by 2 out of 3 HVs, and although seen as positive, their difficulties were discussed more (not multi-disciplinary, not kept by parents, problems with comprehensive note keeping assessment).
Documentation Data The curriculum document showed that partnership issues were addressed in both the health promotion, district nursing and health visiting courses. However, this may be advocated but the dilemmas that this produces did not appear to be specifically addressed, although this may be due to lack of curriculum detail.	The discussion theory vs reality largely centred around different perceptions of need (client/professional/service) with 3 practitioners feeling that they were in the middle between manager and pts.

Commentary	Educational Implications
The rationale behind client led care is well demonstrated by interview data. The gap between ideals of care and the reality seem to be the central feature in this category. It is interesting to note that this is evident in the interviews, but not in the observation data. Client led care demands empathy of professionals and this means that they act as a bridge between various definitions of need.	This category seems to add weight to an argument (building on the overview of needs& Needs Assessment) that education about perception of need is central to an understanding of the difficulties practitioners face in practice settings. This is particulrly important where client centred working is advocated. Stress, ethical issues, and negotiating skills when dealing with clients and management seem to underly many of the situations described. Understanding more about the part that Social policy plays in mediating / creating these situations may have helped students in this case study site.

Category: Joint/collaborative working	**Case Study Site**: L
Data Examples	**Findings emerging from the data**
Interview themes (see Appendix 6L6) With Colleagues in own discipline (Strengths,weaknesses, skill-mix) With colleagues in different disciplines (multi-assessments are positive, SS-HS split & social-health split unhelpful, referrals=wait, information re:involvement of others difficult to obtain) strategies for achieving good working with colleagues (face to face meetings,assertiveness, negotiation, use of client as information source, team member) Period of transition Joint working affords opportunity for supervision and 'measuring up' practitioners ability	All practitioners commented in this area, with the strongest theme emphasising the differences that existed in methods of working. DN2 HV2 & 3 believed that this was useful in assessing clients, partly because of various strengths within the team, but also because relationships developed differently with individual clients. However, DN3 HV1&3 pointed out that different modes of thinking often led to difficulties in decision making.One DN3 saw differences in working as unhelpful, as the philosophy of other DNs working with her clients sometimes produced difficulties in her own relationship with patients. Although relations within this DNs team were good, there was weak evidence to support the notion that it took a while for newly qualified practitioners to get accepted into the team (DN2, HV2). The second theme emerging was that of skill mix. Community Staff Nurses (CSNs) were seen as useful additions to the team by DN3&4 & HV1, with HV1 saying that it freed up her time. DN2 indicated that it was only she who did assessment, although other comments from DN3&4 disagreed with this, stating that CSNs act as another assessor /opinion. The use of the CPT as an agent of change was stated by DN3. Working with other profession in the PHCT was not commented on greatly, but negative examples of this were made by 3 practitioners. Strong evidence that multi-assessments still took place (DN1,3,4,HV1,2), with these being viewed as positive and necessary. There was universal agreement that SS/HS divide (or social / health) split was unhelpful, largely because it was difficult to monitor pts condition across agency care. Three practitioners all DNs stated that resources in SS were short. There was strong indication that practitioners need to be assertive, using negotiating skills (DN1,2,4, HV1) and some evidence that DNs felt "stuck in the middle" of pts and providers (DN1,4). DN1&2 stated that SS were resistant to change, suggestions and ideas. DN1,3,4 HV1,2 all believed that face to face meetings were the vehicle for improving joint working. 2 DNs saw themselves as the central liaising agent within the team. There was wide evidence that change was still going on & still in a transitional state. Both DNs and HVs acknowledged the role of other agencies in community care. contd below->

Observation data

The only instance of joint working observed was a-joint assessment which was very focussed on obtaining resources from social services, and included much negotiation. The patient was included in so far as she heard what was going on, the district nurse acting as her advocate. Indeed, the patient grew concerned when the resources did not appear forthcoming and seemed to withdraw her application as she felt embarrassed that she was a "problem" which could not be solved. Organisational methods which restricted access to services were to blame, since the social services committee responsible for increasing provision to clients had not been set up, and the earliest the applicants case could be heard would be October (this was in April). The social worker repeatedly stated that "nothing could be done" whereas the DN looked to the researcher for ideas about how to manage situation, deciding a letter to SS would be helpful.

Documentation Data

Multi-disciplinary working mentioned in both DN & HV modules, and in advanced courses is placed in context of NHS & community Act. However, refernce lists for both courses are dominated by pre-1990s literature (course validated in 1993). The DN course includes stress management techniques, which might imply a tacit recognition of hte stresses of working in a team.

Interview contd.

All practitioners discussed their own need for supervision, alhtough did not necessarily use the term. They all (except one HV) showed clear need to "measure up" their own assessment, care & professional activity by reference to others, usually but not necessarily from own discipline. All four DNs gave examples where GPs (DN1 consultants) gave guidance or a second opinion when assessing pts. Where menors were an esatblished mode of working they were chosen for the practioner, and on 2 occasions (DN,HV) the relationship between mentor and new practitioner was not good and the usefulness questionable. 3 (Dn/HV) worked in Trusts where continuing education needs were recognised and addressed.

Referrals were often problematic because of long waiting times (DN1,4,HV1,2,), with slight evidence that practitioners were able to circumvent the queuing system (either through personal contact / knowing someone or through getting GPs to refer on their behalf as seen quicker). DNs talked of referrals as preventing overloading, although this has to be seen in the context of their monitoring activity (above). HV1&3, DN1 saw referrals for expert led care, with DN1 saying that this cut out unecessary assessment.

Two DNs discussed care packages, but not with care management in place, giving evidence that this needed to evolve over time. Hospital discharge was discussed by 2 DNs , who valued being invited to meetings prior to discharge.

All practitioners (except 1 HV) talked of getting information about others involvement in clients care. Four (DN/HV) talked of the pt or relative as central to the team because of their role in this.

Commentary	**Educational Implications**
The data emerging form interviews is all discussed by previous research, except for the use of teams as a common method of supervision / standard for "measuring up". Transition as the cause of poor multi-disciplinary working seems to have been cited more frequently than one would expect.	The courses seem to be addressing the major issues referred to by practitioners, and the main message is that they should keep at it, since interviews showed that DNs and HVs find this an important area which demands much energy, and also is a vehicle for continuing education.

Category: Knowledge & provision of services	**Case Study Site**: L
Data Examples	**Findings emerging from the data**
Interview themes (see Appendix 6L7) Knowledge base Changing nature of provision Informal care difficult to track as changes quickly and information is not centrally held. Gaps in provision & ethical concerns.	Practitioners demonstrated a wide and varied knowledge of the formal services available across agencies. There was a wide recognition of the changing nature of provision, particularly evident in comments about affects on own discipline / provision. There was some evidence that knowledge of provision was linked by practitioners to a discussion of ideal vs reality of provision. Practitioners (all except HV3) felt that their knowledge of informal service provision was sketchy, and this was linked by DN1 to frequent changes in these services & the need for a central information point. All practitioners identified gaps in provision, across a wide range of client need. DN1,2,4 & HV 1&2 all commented that gaps in provision of resources resulted in prolonged waits: services were there, but were sparse. This caused some difficulties & acted as stressors for them. DN2,3,4, & HV2,3, identified ethical issues associated with lack of service provision: "pass the pt", rehabilitation, waste of time looking for non-existent services, deterioration whilst waiting, confidentiality, use of student HVs inappropriately.
Observation data Almost 80% assessments utilised practitioner's knowledge about NHS service provision, and passed on information about this to clients. 23% assessments contained information about other service provision. Just over 40% assessments contained information about accessing other professionals, but this was mostly from health visitors. 28% assessments contained information about accessing other services / agencies / organisations. Similarly 28% assessments contained information about other professionals already involved in care. 60% assessments contained information about the service response to be recommended, only 4 assessment visits relayed information about areas of need which couldn't be addressed by the service.	
Documentation Data Profiles performed in courses which were valued by students as a method for geting to know area.	

Commentary	Educational Implications
Needs assessment clearly relies heavily on practitioners knowledge of service provision. Health visitors are morelikely to see accessing professionals / agencies as the clients responsibility than are district nurses. Gaps in provision featured strongly here and caused ethical dilemmas, although this is not shown in the observations made. Practitioners are clearly "taking the strain" of at least some of the service constraints they discussed with us.	Political and ethical teaching needed to prepare for reality of mismatch between NA & provision.

Category: CC Act & Political issues	**Case Study Site**: L
Data Examples	**Findings emerging from the data**
Interview themes (see Appendix 6L8) Erroneous attribution of knowledge. Poor educational experience. Political context of assessment & care.	All practitioners (except oneDN3) had erroneous knowledge of the NHS & CC Act, commonly referring to affects of antecedants of the Act. Four practitioners DN3,4, HV2 & 3 identified an element / parts of the Act , with only one practitioner identifying as many as three elements. Only 2 practitioners were able to link this legislation with split in NA & care between HS / SS (DN3&4). Only 1 (HV2) identified GP fundholding as an issue. All 3 health visitors were able to discuss the purchaser provider split, but not in relation to the Act (other than in the case of HV2 who only talked of GP fundholding). DN1,2,3 discussed SS beaurocracy & social health split but not in relation to the Act. SS-HS split "pass the pt" related to resources (DN1,3,4). Political nature of funding recognised by HV2. Decision making not discussed very fully (DN1,2 related this to resource allocation). All practitioners said that mission statements did not affect their practice. There was some evidence that these were written by management, without involvement of practitioners.
Observation data Only 3 DNs exhibited political knowledge during observation.	One HV2 relayed how she would use a mission statement / standards document as a bargaining tool with education authority.
Documentation Data The curriculum on both DN and HV courses referred to the NHS and Community care ACt, but only vaguely in the DN course. Neither course gave references to much reading material following the act, and the validation was in 1993.	DN1,2,4, HV 1,3 specifically stated that education regarding Act was insufficient "very muddly" "a big yawning gap really" and was taken by a student teacher. Both DNs and HVs recounted how they approached their course tutor re: this and were given a small group session about it, but only briefly.

Commentary	Educational Implications
The ability to recognise legislation in practice was unsurprisingly missing, given the accounts of the course given by students on the subject. Political ways of working were also largely missing from practitioners accounts and observed practice. Political ways of working were referred to in HV (but not DN) course. The curriculum content seems to allow for the possibility that the courses were written to refer to, but not analyse the 1990 act, which would explain why students felt that their education was poor in this area.	Needs to be taught comprehensively by experienced lecturer, relating legislation & theory to practice. This may perhaps reflect the transitional period experienced immediately following the Act.

Category: Education - content overview	**Case Study Site**: L
Data Examples	**Findings emerging from the data**
Interview themes (see Appendix 6L9) Health Policy Needs theory Needs Assessment	DN1,2,4,HV1,3 all believed that their course had contained "nothing really constructive" about the Act. They recounted that they had been taught in lectures about community care in history leading up to the act, but stopped short of recent policy. These lectures were taken by a student teacher. When they approached their course leader about the perceived inadequacy of their teaching about the act, she arranged a small group session to cover it for DNs and HVs. One DN felt that this was also of insufficient depth. This is corroborated by the fact that all practitioners were unable to relate some of the practical difficulties they experienced in working to the act, and ascribed some unrelated general facts to the act. One DN related her lack of knowledge about policy to her status when learning and immediately post-course. The meaning of policy to her role was not obvious. All practitioners except one were able to relate at least two elements of theory about needs to their practice. These were often so embedded in their discussion (especially Bradshaw), without referring directly to the thoery, but practitioners showed great understanding, and it is difficult to see how they would have been able to discuss it so well without reading / education. Teaching about needs assessment (referred to by practitioners) divided into 4 types: referred to models (all DNs), session about record keeping, communication skills & background knowledge needed to perform assesment. One practitioners said that the need to liaise with other agencies was stressed in the course in relation to NA. The health visitors all indicated that they felt insufficiently prepared for conducting NA, although they gave varied reasons for this, which particularly included insufficient knowedge of child development, but also identified that simple models of assessment not included in course. There was evidence that the theory practice gap was problematic when newly qualified. This led one DN to argue that DN course should not lead to sister status, experience should lead to this. The CPTs role was regarded as central in bridging it, (pre & post training) but there was some evidence that she needed education about course and updating too. 3DNs and 1HV said that their training was not sufficiently tailored to individual or professional learning needs, because of large class sizes. The quality of lectures was said to be poor by 2DNs and 1HV.
Observation data None relevant.	
Documentation Data The curriculum is not sufficiently detailed to be specific about what was covered regarding needs or needs assessment in the courses. However, the focus of the DN course appears to be nursing models and the focus of the health visiting course appears to be policy / political nature of needs, needs assessment.	

Commentary	Educational Implications
It is important to note that it was difficult to investigate DN practitioners views about this course. The interviewees were circumspect about criticising their course, particularly their course leader, who was clearly well liked and respected. One person felt that too much was expected of her in her role at the college. Two DNs recounted occasions where she had visited them in practice and had been supportive and helpful in dealing with problems. It is probably of enormous significance that they all criticised aspects of the course which were about needs and needs assessment. The interviewers believe that there was probably unaccessed frustration / emotion present about the course in this case study site.	The educational context in which teaching about needs and needs assessment takes place is important to investigate further before any precise recommendations can be made, although it is clear that problems existed for students in their learning. Students found it easier to relate their knowledge about need to the practice setting, whereas their learning about policy was more difficult. This is likely to be addressed by attempting to ensure that policy issues are made relevant to students' current practice. Newly qualified practitioners are likely to be primarily coming to terms with the "what is" rather than the "what was" or "what will be", which is addressed by policy.

Category: Education - process overview	**Case Study Site:** L
Data Examples	**Findings emerging from the data**
Interview themes (see Appendix 6L10) Classroom learning. Informal learning, On the job training.	3 DNs and 1HV openly stated that large class sizes were unhelpful and this seemed linked with the lack of individually tailored teaching. However, of these practitioners, 2 said that mixed groupwork was helpful as it enhanced learning from peer groups and another HV agreed. There is clearly some balance to be struck here, as contradictions existed in individuals' account of mixed professional groups. 1 DN and 1HV said that this method of teaching should be used specifically for NA as this would help learning. However, evidence from 1 DN suggests that groupwork should be carefully structured as it can lead practitioners to confused accounts of a subject (research) with student being able to discern "no answers". 3 DNs could identify learning that took place in the process of education which could not necessarily be measured by conventional methods (ie think about things in a different way). 1 DN particularly related this to things which were not immediately relevant, but were in the course. This could take place in classroom or as a result of assignments (not necess. performed well). The classroom itself, coursework guidelines and teaching were described by individuals as being unsatisfactory. Informal course learning was largely mentioned as being instigated by the students. The fact that too much was expected of the course co-ordinator was stated by 1 student. 2 HVs particularly valued self directed learning. The central role of the CPT both pre and post qualifying was a strong theme in preparation for practice, being most requently described as a "role model". Five practitioners stated that their CPT was unsatisfactory in some way, and this was related to relationships, knowledge of course and of practice developments. 2 DNs stated that they felt that the college had far more responsibility to ensure that CPTs were offering what was needed, although one tutor offered support (but CPT not changed).There seemed to be a large amount of "measuring up" post-qualifying, where practitioners used peers and others to judge own practice. The importance of supervision after qualfiying was stated by 1DN and 2HVs. Settling in to the job once qualified seemed to be linked both to team's attitude to practitioner and to continued ability to learn. One practitioner who had changed areas post qualifying felt she needed an induction to her new job.
Observation data None relevant	
Documentation Data. The curriculum showed that each course studied used a wide variety of techniques for classroom learning. The links between the case study site and their CPTs were said to be good, and the curriculum showed that link CPT study days were integral to these. However, they did seem particularly burdensome, and it is easy to speculate that their maintenance may suffer where staff are pressured. The interviews contained information which showed that students themselves believed that their lecturers were working with extremely high workloads. The curriculum also showed that the course is founded on the philosophy of multi-disciplinary core learning modules for CPNs, DNs and HVs to study. Whilst this is laudable, the increase in the intake of students at the re-submission in 1993 appears to have caused problems according to the interview data, and was not addressed within the curriculum.	

Commentary	Educational Implications
Practitioners were far more likely to mention structural problems with the course than individual teaching standards. All practitioners saw the course as the beginnning of learning, and evidenced this in their desire to measure own practice against others, or for supervision. Settling in to their role seemed to be linked with ability to learn. There are clearly great problems with CPTs and their links with the college. The college does not seem to be taking a proactive approach to ensuring CPTs are of sufficient standard in a range of ways. However, where CPTs were good they were valued very highly by students.	The use of groupwork was sometimes valued highly and sometimes described as poor. This seems to be linked with acknowledgement within exercise of individual ability and proper feedback afterwards. It seems that the timetabling structure & environmental facilities of this course may be problematic, and although this may be an artifact of the students reluctance to criticise individual teaching ability, there were some detailed suggestions of improvements which are likely to aid learning. The pressure on educational institutions to engage in mass teaching, seems to be singled out particularly for criticism. CPT links need to be developed, so that where possible educators have some influence on maintenance and development of their knowledge and skill in order to continue in this role. Regular review of CPT performance seems necessary in the light of the practitioners commments. Post qualifying experience seems critical in developing confidence in the students. There is a challenge for professional leaders in deciding how best to ensure that consolidation and extension of learning occurs immediately post qualifying..

Case 'M'

The educational institution was situated in a heavily populated city, but drew students from a wide geographical area. It also has a long history of running community nursing courses, and the health visiting and district nursing courses. The university itself has undergone significant changes in the last 5 years, with major organisational and cultural shifts. The diploma course was validated by the ENB soon after the NHS reforms, prior to our participants enrolling on the course.

Students were largely employed in NHS Community Trusts which served semi-rural, urban and inner city populations, although there was some evidence that GP fundholding was changing the nature of employment within our sample. Trusts generally served an ethnically diverse population. There were no particular issues raised of ethical concern during applications to the ethic committees.

The small number of district nurses recruited to the study reflects the size of the course cohort, and the problems that faced newly qualified practitioners in obtaining jobs in the locality. Many district nurses only obtained employment after some months of searching, and these were often at the lowest post qualification grade (D). This is thought to have had a significant effect on the final sample, since those with low grades and little post qualification experience were reluctant to take part in the study. This contrasted with the relative ease of employment for health visitors, who were usually graded at 'G' level.

The following table shows the numerical information pertinent to the sampling process:

CASE M	District Nurses:	Health Visitors:
Cohort size	9	27
Number contacted by researchers	3	26
Number agreeing to take part	3	10
Final Sample	2	6
Number of Trusts	8	
Number of Ethics Committees	8	

The findings from the observation, interview and curriculae from case 'M' will now be presented in tabular form, according to the themes derived from the framework used in analysis.

CASE M; THEME 1:
NEED AS A HOLISTIC CONCEPT

Data summary	**App 6M**	**Findings**
interview themes	key	The idea of 'need' seemed firmly linked to an holistic ideal, the extent of which varied from one context to another (ie, whole individual, family, area or group). The ideal was expressed in relation to an apparent belief that this provides the essential underpinning for a personalised, responsive, 'needs led service'. This was generally expressed interchangeably with the idea of a 'client-led service', although there was recognition that this was not necessarily the reality in practice (see Themes 3, 8). The division between health and social need appears to be recognised in relation to service provision, and in specific, usually formally defined situations when a specific assessment is required. However, no such division was discernible in data relating the concept of need to individuals, families or communities, and the idea of dividing it in such a way was firmly disputed at times. There is a striking absence of data in which 'need' is articulated as a 'pure concept' although the practitioners related having learned about it, with varying degrees of apparent understanding. This suggests that 'need' cannot be fully conceptualised apart from the context in which it is being considered, or as separate from the exercise of needs assessment (see Themes 4, 6). This summary avoids including examples which are closely bound by such context-related features, although those elements which stand alone (as identified here) recur throughout the remaining themes, suggesting that the foundation of a concept of need underpins them all.
need is articulated as:		
• a holistic concept	1a	
• a complex, changing and continuing issue	1a	
• in conjunction with health, well being, personhood,	1b	
• personal, subjective; linked with individual perceptions	1c 7a	
need is articulated in relation to:		
• specific clients, hypothetical practice situations (examples) or elements contained within need	1b 1c	
• contract specifications, protocols, service provision	2a	
• bound by context	2b	
• recognition of client views, perceptions, rights, values	4b 4e 7a	
• different levels: individual, family, area, group	1c 2b 3a 4e	
• different depths of need: superficial, deep, hidden	2a 2b 1b 1c	
health needs, social needs	3b	
• explained together: as if inseparable	4d, 7b	
• division described only in relation to service provision,	1b	
specific issues	2e 4e	
'need' rarely expressed in the abstract		
• except when explaining how need was taught in college	1a 1b	
• occasionally in direct response to question	1a	
observation data not observable in the abstract, but discussed identified need/condition with client in 19 visits		
curriculum document notes importance of developing 'higher order' intellectual skills (p115); holism associated with patient care(209) and with client centred intervention (p72) 'need' not identified as specific issue; health and social needs not distinguished		

CASE M; THEME 1:
NEED AS A HOLISTIC CONCEPT

Commentary	Educational implications
This anlaysis helps to link the notion of need to the literature and analysis from focus groups • the philosophy and ideal of 'need' which underpins assessment in policy and practice, (Bradshaw, 1972, Doyal and Gough 1991, Lightfoot, 1995) • the philosophy and ideal of primary health care: participation, client led, community and family based (WHO 1978, 1986); • definition and concepts of health (Seedhouse 1986, WHO 1986)) Questions arising from this analysis are: Why is it difficult to conceptualise, and is it important? Is the ability to conceptualise linked with ability to cope with ethical/resource dilemmas in practice? The impression from interviews was that those respondents who were best able to conceptualise were also least 'thrown' by these difficulties . The sample was too small to make such conclusive generalities, but educational theories of academic development would support this view.	Educational theory supposes that intellectual development (ie, ability to conceptualise) supports an ability to articulate difficulties, and helps to develop the confidence from which to negotiate them with appropriate people - like GP fundholders, managers etc. This is an important issue in terms of academic level; ability to generalise and conceptualise should be established at degree level (level 3).

CASE M; THEME: 2 THE CONCEPT OF NEEDS ASSESSMENT		
Data summary	**App 6M**	**Findings**
interview themes timing of needs assessment is concerned with	key	Needs assessment emerged from the analysis as an activity which was, paradoxically, both integrated into the whole work of the community nurses, and discernible as a distinct, specifically purposeful activity. At times, assessment appeared to be a first step in the planning of service provision, at others, it seemed to be an end in itself (see Themes 1, 6, 7). The practitioners needed to be adept at shifting their stance according to wide variety of circumstances, which was achieved more successfully by some than others (see Theme 5). Superficial or 'easily seen' needs were sometimes still serious in their effect on patients or clients; they included crisis situations, needs which must be met immediately or which could not be left, as well as relatively simple, short term needs. More complex, long standing or deep-seated needs which were not immediately obvious, but were discernible on examination or enquiry sometimes required formal, multi-disciplinary and multi-agency assessments. Finally, those which were most difficult to elicit were possibly obscured by circumstances or overlay of more obvious or pressing needs, were hidden and required great skill to elicit. These were often intertwined with the different levels of need - at family or group (eg, social class) level rather than affecting single individuals, and their assessment was not always supported within the service structure (see Themes 1, 3, 4, 7). Each aspect of the assessment - timing, different level and depth, degree of formality, complexity and afforded value - appeared to be independent of the others, so that any combination or variety might arise in practice. The practitioners needed, therefore, to develop a very wide repertoire of knowledge and skills to be able to respond appropriately to the needs they might encounter or be expected to assess (see Theme 5)
• past: identifying history, culture, background in personal/individual terms	2b 2e 3b 4b	
• present: immediate or current actual need for service	2a 2c 2e 4d 5a 6b	
• future: potential needs, planning ahead, in terms of health promotion and preventive care	2b 2d 3c 4d 6b	
• according with client's perception of need, and their readiness to discuss;	1a 1b 1c 3b 3c 4b 7a	
• achieving service requirements: policy and constraints	1c 2d 2e 3a 3d 4a 4b 4e	
• a single event, or a continuing process	2a 2b 2c 3a 3b	
a holistic philosophy underpins the idea: at different		
• levels: focus on individual; family; whole area, group or caseload	1c 2a 2b 2c 3a	
• depths: superficial or 'easily seen' needs; deep or deep-seated needs; hidden needs	2a 2b 1b 1c 3b 3c 7a	
and with different degrees :		
• of formality: from very formal to (purposefully) casual informality	2a 2c 7b 8b	
• of complexity: single or specific issue, multiple issues, interlinked or interdependent issues	2a 2b 2d 3b 1b	
• of acknowledged value or importance, according to perceptions of 'health' and its link with need, service structures (health and social) and contract specifications.	1c 2a 2e 2d 2e 3a 3b 4b 4c 4d 4e 5a	
observation data wider context: client (13) family (11); social network (3) informal, structured seen; full formal assessment not seen search for hidden needs: 19 visits unexpected/unpredicted needs - most HV visits; not in schedule so not counted		
curriculum document common core: social environment and family (p65). HV-profile needs of individuals, families, communities (p98) DN- neighbourhood profiles (p212)		

CASE M; THEME: 2

THE CONCEPT OF NEEDS ASSESSMENT

Commentary	**Educational implications**
These multiple approaches may be a development of the holistic ideal based in primary (first level) nursing socialisation or the secondary socialisation of practitioners into existing community nursing practice after they qualify. However, there are links with theory and literature: • The idea of the 'principles of health visiting' (CETHV 1977, Twinn & Cowley 1992) especially the 'search for health needs' (Chalmers 1993), especially where hidden or unexpected (Cowley 1995a) and 'stimulation of an awareness of health needs' (Cowley 1991b) • The idea of family nursing (Friedemann 1989, Orr 1992a, Wegner and Alexander 1993) and its links with participation in care (Coyne 1996) • The theory of nursing at a community level (Chalmers and Kristjansen 1989, Orr 1992b) and development of public health nursing (Cowley in press, SNMAC 1995) • profiling/needs assessment literature (Billings & Cowley 1995, Twinn et al 1990) The introduction of new policy and formal, systematic approaches may build on these existing theories, rather than being viewed as something 'totally new'.	There is a need for strong basis in psychological, sociological and epidemiological theory to establish a sound knowledge base upon which to build practice. This needs to underpin the specific community nursing knowledge, relating to: • Family nursing theories, community-as-client theories, profiling, community needs assessment. • Systematic assessment; use of models/tools. • 'Intuitive assessment'; understanding why this is necessary but not sufficient at an individual, family or community level • eliciting information - communication skills; discrimination/awareness of limitations and strengths of subjective, professional judgement - research skills

CASE M; THEME: 3
THE POLICY OF NEEDS ASSESSMENT

Data examples	App 6M	Findings
interview themes NHS and Community Care Act 1990 • client led, needs led ideal • internal market; GP fundholders, purchaser agreements • interagency working; care management • separate service responsibilities: health and social strategies for implementing policy • at team level: nursing/health visiting teams; practice teams; team meetings; formal and informal support • at Trust level: working parties - records, standard setting, discharge planning; meetings • intersectoral and interagency level: liaison; joint strategies • practitioner involvement vs management lead • needs assessment for planning services • Trust philosophy; feedback mechanisms implementing policy in practice • conflicting priorities • resource constraints • assessing client needs within a structural context	key 1a 1c 2d 3b 2d 4e 7a 8b 1c 4b 5a 8b 1b 2e 2e 5a 3c 4e 6a 6c 8a 8b 4d 6a 3c 4a 5a 6a 2d 4d 2c 2d 4b 4c 4d 1c 2a 2d 4a 4b 4c 4d 4e 7a 2e 3a 4a 8a	Understanding of the NHS and Community Care Act varied widely, and appeared to link as much to the post-qualifying experience and discipline of the community nurse as to the teaching they had encountered in College. Unsurprisingly, the health visitors expressed more familiarity with the Children Act than implementation of the Community Care Act, but the district nurses displayed limited actual experience of case management or joint complex assessment. Both experienced interdisciplinary and interagency liaison, in formal and informal assessment situations (see Theme 7). The extent to which the practitioners were aware of an impact from the internal market also varied. It seemed linked to the extent to which they appeared to feel able to control their own practice; both negative and positive views about purchasers (especially GP fundholders) were strongly expressed at times. The extent to which professional self-confidence was apparent seemed to be linked to a variety of influences, such as relationships with immediate colleagues, team members and management, and the manner in which strategies and purchasing agreements were developed within the Trust (see Theme 8). A common theme arose from a difference between the acknowledged positive ideals of policies and strategies, and implementation which often appeared to contradict them. The notion of need as a holistic ideal (Theme 1) which should underpin assessment and service provision (Theme 2) was especially likely to be countered by a combination of resource constraints, and strategies designed to clearly specify assessments and service responsibilities (Theme 4).
observation data eliciting/recognising client view of need (22) discussions around resource constraints/waiting times and availability etc, especially where need fully established	2b 3a 3b 3c 4a 4b 4e 6c	
curriculum document Validation prior to introduction of NHS & Community Care Act, so not mentioned in document. Knowledge of relevant laws policies specified for HVs (p99)		
practice: assessment documents different assessment documentation seen; not collected		

CASE M; THEME: 3
THE POLICY OF NEEDS ASSESSMENT

Commentary	**Educational implications**
This section links the analysis with policy documents setting out 'ideals' of Community Care Act 1990 and the Children Act 1989. Both emphasise the ideals of services being client led, with professionals across different agencies and sectors working in collaboration; both emphasise the responsibilities of specific agencies to meet assessed needs. The impression in the data is that such formal assessments are a minor element of the work, which raises questions: • is it part of the alleged NHS withdrawal from long term care? • is it related to the social services lead for formal/complex assessments under Community Care Act, or for children 'in need', which removes nurses from the process? There is some other literature which supports the view that the internal market 'ideals' of contract setting as a needs led process may create conflicts and lead to dilemmas in practice (eg Duggan 1995; Glennerster et al 1994, Russell 1995). The data offered an impression that those practitioners who appeared most confident/self empowered, also seemed to be those who contributed to policy/strategy development in some way (even if for example, it was just by acknowledging when they had an opportunity to comment on the output of a working group). There is no way of knowing the direction of the causal link (ie, whether confidence leads them to contribute to the policies, or contributing to policies gives them confidence). However, for educational planning purposes, it would appear beneficial for practitioners to know how to contribute to this kind of planning	Gaining experience of formal assessments was problematic for some - ?how to address this Understanding required of both • the basis of national, established policy, • and the manner in which local Trusts, purchasers, planning consortia etc were implementing the policies. The second of these will require a good input from teaching in practice, since Colleges will not be able to provide specific individual input for every separate trust and practice served by practitioners educated at a particular College. The College will however, need to teach principles of developing strategies to implement policy, and the ability required to contribute meaningfully to their development: eg, debating, advocacy, teamwork, presentation skills.

CASE M; THEME: 4 THE CONTEXT OF NEEDS ASSESSMENT		
Data examples	**App 6M**	**Findings**
interview themes	key	A perceived need to conserve and rationalise resource use was expressed in much of the data, with varying degrees of understanding. Both innovation and responsiveness to needs required awareness of time constraints; in some instances pressure of work was described as a prohibiting factor. Discussions at practice or Trust level meant that some practitioners worked with aims and targets which they felt reflected the needs on their caseloads (see Theme 3). In other situations targets were decided 'higher up'; these sometimes appeared unconnected to the needs of the clients being assessed. Referrals featured in most of the data, with community nurses both making and receiving them. Making a referral might reduce pressure of work by relieving the practitioner of continued responsibility for that client (eg, in cases designated as 'social need'). More often, referrals were associated with continuing, if shared, responsibility, with the added need for liaison and inter-agency working (see Theme 7). Purchaser agreements and monitoring patterns were described in broadly numerical terms, emphasising quantity and specification. This contradicted the unpredictable and variable needs encountered, and the sensitivity required for client-led services (see Themes 2, 3). The selection of an appropriate mode for assessment appeared to be related to a combination of both the service context ('knowing' services and individual providers), and to the family, area or ethnic culture of clients being assessed. Awareness of clients' priorities, and that these might differ between family members or within a community, was an additional feature to be considered.
Needs assessed in the service context		
• targets: established at practice, Trust or national (eg, GP contract, Health of the Nation) level	1c 2a 2c 2e 4b 4c 6a 2e	
• resources: time pressure, services available	3a 4a 4c 8a	
• emphasis on quantity; disputed priorities	1c 2a 2d 3d	
• responsibilities: health and social services; designated responsibility; continuing or completed responsibility	4c 2e 4e 5a 8b	
• referrals: making and receiving; formal and informal	6a 6b 8b	
Needs assessed in the client context		
• selecting appropriate timing, level, depth and degree of formality for assessment	2c 2e 3a 3c 7b	
• 'expecting the unexpected' - unpredicted needs	1c 3c 7b	
• awareness of diversity (including ethnic variations) within families and in the area	2b 3a 7a	
• recognising variability; conflicting needs in family; disputed priorities and ethical dilemmas	1a 1c 2b 4b 4c 8b	
• obtaining and using resources for client; advocacy skills	3b 4a 8a	
observation data managing resource constraints/negotiating with client; discussing formal and informal referrals with client: *information* about NHS provision (16); other services (9) *access* to other professionals (8); to other services (5); mentioned other professionals already involved in care (12)		
curriculum document client centred approach in HV module (p117) skills of making referrals in DN module (p212)		

CASE M; THEME: 4
THE CONTEXT OF NEEDS ASSESSMENT

Commentary	**Educational Implications**
Service context: The ideals and actuality of contract setting are highlighted in Theme 3. The importance of team working is shown, both for practitioners to feel some ownership of aims and targets to which they are supposed to direct their energy, and the importance of keeping client needs uppermost (eg, Griffiths and Luker 1993, Poulton 1994, Poulton and West 1993). Team working may link with ideas of felt responsibility, which appears not to have studied as a specific phenomenon. However, much health visiting literature refers to notions of 'sole responsibility' (eg Appleton 1994) and extending the role beyond formally acknowledged boundaries (eg de la Cuesta 1993, Campbell et al 1995). Some of the complexities of making referrals were unpacked in a study by Luker and Chalmers (1989). Disputed priorities may arise from a mismatch of data collection for establishing needs; the literature discusses difficulties arising from wrong assumptions (Cowley 1994) or from wrong geography (Chase and Davies 1991, Young and Haynes 1993). It may be difficult for practitioners to relate to targets established at a distance from the client (eg GP health promotion contract (DoH 1990a) or Health of the Nation (DoH 1992)). Client context The unpredicted/unexpected nature of practice has been explored by Cowley (1995a), who also explains the apparent importance of maintaining the whole socio-cultural context for assessment, especially in relation to health promotion (Cowley 1995b). Dilemmas of prioritising within families are not much explored in the literature, especially when individual clients have specific needs (eg people who are terminally ill, or children). However, when care is required over long periods, there is concern that concentrating on one individual alone may militate against the welfare of carers and their access to services (Twigg 1989). Carers are increasingly elderly and in need of consideration themselves (Askham et al 1992), and there has been long concern about the way that concentrating on children inhibits parental access to health visiting services.	Theoretical understandings need to be tempered with awareness of resource constraints within the 'real world'. Practitioners are likely to be involved in prioritising within the context of managing their own caseloads and of covering for vancancies, so need to develop • time management skills • strategies for coping with working under pressure • ability to 'rise above' turmoil and urgent requirements to prioritise systematically • ways of assessing whether shortcuts are 'acceptable' within principles of 'good enough' care The great variability of each assessment context also suggests that practitioners need to develop confidence in their own judgement of unique situations. To develop an ability to integrate understandings from a whole range of perspectives, and to obtain resources for clients (eg, through referrals and advocacy), a high level of teaching input in the practice situation will be needed.

CASE M; THEME: 5 **LEARNING TO ASSESS NEEDS**		
Data examples	**App 6M**	**Findings**
`interview themes`	**key**	The extent to which practitioners recalled being taught about needs assessment varied quite widely, despite them all having attended the same course or College. Actual practice experience was highly regarded as a means of developing assessment skills. Variations in taught and supervised practice experiences may account for some of the differences in perception; whether this period had been positive or not, the practitioners noted the extreme importance of the practice teachers in facilitating this learning.
learning skills, knowledge and ability		
• different levels and depths of need		
• models: Orem, Bradshaw, Becker, Clark, Robertson,	1b 2a2b 2e	
Maslow; specific tools or tests (eg, Scriver, EPDNS)	1b 2a 2c 8a	
• documentation	2c 3c	
• reflective practice	3d 4a 4d 5a	
• practice experience: CPTs, assessors/supervised practice	8a	
	5a 8a	
building a repertoire of experience		
• using peers and colleagues as a resource	2b	Practising the use of different types of nursing models, tools and approaches to assessment, and the relevance of reflecting on practice were well recognised, but sometimes only with hindsight. There was some variation in the extent to which practitioners were able to clearly explain in the interview the multiple aspects of assessments they had undertaken earlier in the day, but the majority were articulate and appeared to have a realistic level of confidence in their skills.
• getting to know clients and area	3a 6a 6c 8a	
• getting to know services and service providers	2a 2e 3a 4a	
	2a 4a 6a 8a	
putting it all together		
• systematic vs intuitive approaches		
• developing confidence	2b 2c 2d	
• developing awareness	4d 4e 8b	
• developing skills	2e 7a 8b	Most practitioners were able to build a repertoire of experience by encountering a variety of different situations before and after qualifying, eg by undertaking visits and ensuring they gained a range of experience. To consolidate their skills they needed to obtain suitable employment after qualifying. Support from more experienced colleagues enabled some to 'talk through' uncertainties on returning to their base. Others worked in isolated situations, or with colleagues whose approach seemed less helpful. Explicit recognition of personal responsibility for developing and maintaining professional expertise seemed to be present where practitioners also displayed self-confidence in managing their own workload and assessment practices.
• responsibility for professional development and learning	3c 7a 8b	
	4e 8a8b	
`observation data` family involved in assessment + handling diverse situations, unexpected/unpredicted situations and needs knowledge use observed: service provision (15), ethics (4) pharmacology (11; development (15); research (6); sociology (1); psychology (4); biology (11) pathology (11)		
`curriculum document` Common core: interrelationship of personal & professional identity, through experiential learning (p71). HV modules: models of assessment, systematic approaches to recording data; foundations for 'professional artistry' (p113, 117)		

CASE M; THEME: 5
LEARNING TO ASSESS NEEDS

Commentary	Educational implications
The importance of integrating technical and intuitive knowledge to develop the expertise required for this level of practice is not a new finding. It has been explored by Benner (1984), Benner et al (1992) and (specifically for community nurses) by McMurray (1992). The importance of community nurses developing skills of professional artistry (Schon 1983) and professional judgement (Eraut 1994) emerged from research by Mackenzie (1992) for district nurses, and Twinn (1991) for health visitors. The health visiting course in this case study site afforded specific opportunities to practice using specific assessment tools, instruments or models and to learn about reflection on practice. These were singled out as helpful by the majority who had experienced them. There were three issues relating to preceptorship/period of consolidation following qualification: • difficulty in obtaining employment on appropriate grade affected the opportunity for some practitioners to consolidate their skills. • the amount of actual experience during the course appeared too little for most practitioners to really develop a full repertoire of experience. • the diversity of good peer support available for newly qualified practitioners questions the value/existence of meaningful 'preceptorship' period. While it was reported as excellent by some; others appeared very isolated, or received support mainly from other disciplines. It seems likely that this situation will increase with GP fundholding and breakdown of discipline specific teams/clinic bases.	The relevance of professional artistry and of practical skills in assessment are such that they need to be specifically targeted in courses of preparation. The importance of Community PracticeTeachers and Assessors of Supervised Practice was underlined by the centrality of learning from and through experience in practice field. Without exception, where this supervision was perceived as inadequate, the learning in College did not have the power to compensate; where it was good, it was considered extremely helpful in promoting the integration of theory and practice to a significant degree. There is a link with educational contracts, as meeting these requirements will depend on the suitability of community placements, including availability of skilled practice teaching, and manpower planning to ensure students are given the opportunity to consolidate their learning experience once qualified. Given the difficulty of some students in achieving sufficient practical experience during the period of the programme of preparation, the overall reduction in course length which has since been introduced under the PREP regulations (UKCC 1994) must be viewed with concern.

CASE M; THEME: 6
ASSESSMENT AS EVERYDAY WORK

Data examples	**App 6M**	**Findings**
interview themes	key	The idea of 'needs assessment' rarely featured in the data as a single activity, separate from the rest of the work. There were references to times when specific elements of need were sought, or when priority was given to particular aspects or individuals. These were often associated with formal assessment situations, which had either been so designated by a Trust protocol or purchaser agreement (eg, primary visit to a new born baby) or following specific expectations arising from the Community Care Act (see Theme 3). Such specificity was acknowledged as important, not only for the purposes of fulfilling purchaser agreements, but also for focusing the contract between client and practitioner, especially when they first met. The idea of delegating planned work to a junior ('skillmix') team member following assessment featured in few instances, with no district nurses and only one health visitor describing direct experience of this kind of division of labour. However, sensitivity to the client situation meant that much assessment occurred in far less formal way. Much of it appeared intimately enmeshed with the rest of the work, to the extent that questions about assessment were answered in terms of the whole of community nursing work - in planning for the specific client, as well as the rest of their caseload and professional responsibilities. All but the briefest visits were considered as being about assessment to some extent. Likewise, liaison between health, social and other services, seemed as often to be described as part of everyday work as to be linked with formally designated responsibilities (see Themes 1, 2 and 7).
assessment as a means of:		
• achieving targets/purchaser agreement	2a 4b 4c	
• prioritising services/caseload management in general	2d 3a 4a 4d	
• promoting joint working	3c 6a	
• planning and delivering services for assessed client	3b 3c	
• forming relationships with client	2d 3a3c	
assessment involves		
• knowing context: client, family, area	2b 3a 3b 8b	
• knowing context: services, service providers, informal services/resources in area	2b 3a 8a	
• documentation: administrative issues; client records; computer systems	2a 2d 3d 4a	
• starting from a narrow starting point, then extending	2a 2b 2d 3c	
formal assessments		
• NHS and Community Care Act	2e 5a	
• interagency working	4a 6a	
• specific situations; eg, elderly, disabled, child protection	2e 5a	
observation data 8 assessments apparently complete (4 first, 4 subsequent visits); 19 apparently incomplete (9 first, 10 subsequent visits); follow-up contact (home or clinic) arranged: 22 cases		
curriculum document assessment linked to principles of health visiting (p111) needs assessment not specified for district nursing; holistic concept of patient care stressed (p209, 217)		

CASE M; THEME: 6
ASSESSMENT AS EVERYDAY WORK

Commentary	**Educational implications**
This follows directly from theme 5; skill in needs assessment appears to be linked to overall professional ability and a wide discipline-specific relevant general knowledge (eg, all observed district nurse visits involved the overt use of knowledge of pathology, while health visitors displayed child development knowledge in nearly all visits; see Theme 5). The knowledge encompasses recording and reporting mechanisms in addition to clinical ability and skills of forming relationships with clients. There is something of a paradox in that needs assessment appears inseparable from the rest of the work, and yet is clearly distinguishable from it certain circumstances. The implication from this interpretation is that the connectedness is conducive to client sensitivity and individual responsiveness. Arrangements to follow up or maintain contact with clients did not seem particularly related to whether the assessment was complete or not, perhaps because some practitioners were covering colleagues' caseloads, and there were 'emergency' arrangements because of shortage of staff in other areas. The lack of delegation, 'skillmix' experience and detail seems surprising, especially from the district nurses who usually work in teams, but one of the two practitioners was employed in a junior grade, despite her qualification.	There is a need to develop professional practice as a whole as this has a direct impact on needs assessment. This includes: • Practical issues, such as clinical knowledge and skill, and maintaining records • Managerial issues, such as collating information, computer systems, caseload management, delegation and accountability in skillmix teams • Planning, prioritising and arranging follow up contacts where resource constraints preclude full assessments and return visits.

CASE M; THEME: 7 **WORKING TOGETHER IN POLICY AND IN PRACTICE**		
Data examples	**App 6M**	**Findings**
interview themes	key	For most of the practitioners, the idea of 'joint working' was specifically, but not exclusively, associated with the NHS and Community Care Act. The health visitors noted similar requirement to 'work together' under the Children Act. Both sets of legislation specify formal and particular occasions (see Theme 2) when a joint assessment is required, but these appeared to be a very small minority of cases in practice. No joint assessments were observed, and the practitioners recalled few occasions when they had been involved with these formal events. However, many assessments involved an element of working in conjunction with other disciplines and across agencies (eg, with midwives, GPs, social workers, family centre/family work teams, hospital nurses/specialists). Liaison and referral, likewise, appeared to extend along a 'continuum' of formality, with everyday 'just mentioning' an issue to a colleague (eg, GP or midwife) who would be contacting a client anyway at one extreme, and formally constituted joint assessments, referrals and case conferences at the other. Interpersonal relationships, particularly with GPs, appeared particularly significant in creating conditions conducive to the more common, everyday joint working. Some of the practitioners had been involved, or were aware of, the strategies and policies for joint working which had been developed at the level of the Trust or purchaser. Others appeared to demonstrate little awareness of what was being decided at a 'higher level', or considered that little feedback was available about how any information they fed into the 'system' was used.
working together in policy		
• joint working: Community Care Act; formal joint assessments; projects; official meetings; shared records	2e 3d 4a 5a 6a	
• practitioner involvement in establishing strategies, policies, liaison	4c 4d 6b	
• feedback from 'higher up' (eg Trust board) to practitioner	4c	
• referrals: formal; through official channels	4a 5a 6b 7b	
• designated responsibilities	2e 4b 4e 6a	
working together in practice		
• team work: getting on with colleagues; informal liaison; respecting colleagues' judgement/role	3a 6a 6b 6c 8a	
• informal referrals: within team; across disciplines	6b 7b 8a 8b	
• shared responsibilities: across agencies and disciplines	4e 6a 6b	
• 'getting to know': colleagues, area, services	2d 2e 3a 8a	
• advocacy and partnership: involving clients	3b 6b 7a	
observation data seen discussing other services, advice given etc with clients: discussion/professionals already involved in care (12); accessing other services (5) or professionals (8) (Theme 4)		
curriculum document common core: inter-disciplinary workshop to encourage broader view, beyond own discipline + develop skills of advocacy (p71) HV module - networking processes with statutory, voluntary, formal and informal agents (p98) DN module - emphasis on teamwork throughout; meet other health care organisations/agencies (p217)		

CASE M; THEME: 7
WORKING TOGETHER IN POLICY AND IN PRACTICE

Commentary	**Educational implications**
This is a close parallel to theme 6; the idea of 'working together' appears as a central part of everyday work, and yet is clearly distinguishable from it certain, formally defined circumstances. This may be an artefact of the interview schedule, but it does appear to reflect the experience of the practitioners, for whom the more formally defined situations represented a minority of their work. The importance afforded to multi-disciplinary, multi-agency working recurred throughout the data, although the dearth of experience of formal, systematic assessments is a source of concern. This may be partly due to the newness of the 'community care' part of the NHS and Community Care Act, which was only implemented at the end of 1993. However, data for this study were collected in mid 1995; nearly two years after implementation, newness should not be a major issue, and the Children Act 1989 has been operational since 1991. Some practitioners expressed a lack of understanding, insight and feedback about what happens to information sent 'up' to service and contract managers. This may relate to their newness within the practice teams or in working in particular trusts, but it emphasises once more the importance of teamwork highlighted in theme 4.	Students need access to sufficient formal assessment situations to fully understand the differences between these and the 'everyday' work of assessment. This is a contracting issue, as it is clearly places quite a heavy burden on the community placement. Skills required: • networking, identifying services • teamwork skills: both team leadership skills (as themes 4 & 6) and contributing/maintaining and encouraging the development of task or client specific teams, or PHC teams etc. • client/service relationships: advocacy, referrals/liaison (especially at an informal level); participation and partnership with colleagues as well as clients.

CASE M; THEME: 8 THE REALITY OF PRACTICE		
Data examples	**App 6M**	**Findings**
interview themes learning and development facilitated • experience in practice; consolidation after qualifying • theoretical knowledge base relevant to practice • support: from colleagues, team members • afforded respect for judgement/opinion/role • realistic awareness of constraints • personal responsibility for own continued development • collaboration, joint working, discussions/meetings • opportunity to engage in developing strategies etc • policies consonant with client/needs led philosophy learning and development hindered • professional judgements/opinion not respected • resource constraints • conflicting priorities; contradictions to client led, needs led or holistic philosophy • enthusiasm undermined by colleagues • low morale in colleagues/team members • insufficient/delayed feedback from 'higher up'	key 5a 8a 8b 5a 8a 3c 6a 6c 8a 4a 4e 6b 6c 2e 3a 4e 8b 4e 8b 3c 4e 5a 6a 4d 6b 1c 2c 7a 4c 4d 4e 6b 6c 2e 4a 8a 2d 3d 4b, 4c 4d 6c 6c 4c	The diversity of situations in which the practitioners were working, in terms of both their employment context (structure and ethos) and the variability of client needs, was striking. This was reflected in the vast diversity of assessments which the practitioners were required to carry out. Prominent and recurring features were the inseparability of needs assessment from the rest of the work (see Themes 2, 6, 7), the unpredictable, unexpected nature of needs assessment (see Themes 2, 4), pressure of work through lack of resources (see Theme 3, 4), and interpersonal relationships within the work context (see Themes 3, 5, 6, 7). The development of professional expertise, likewise, appeared to follow a personal trajectory for each practitioner. Important factors appeared to be an ability to integrate previous knowledge (usually beneficially) into their current role, and the quality of practice experience during training and after qualifying. Theoretical knowledge from College teaching gained relevance as the practitioners met situations to which they could apply the theories in practice. No clear basis for suggesting causal relationships was evident, but practitioners who appeared the most confident about articulating their assessment practices were also able to detail strategic and management arrangements at Trust or practice level, and felt their opinions and judgements were respected. Another feature, especially noticeable in the more confident, was an explicitly adopted personal responsibility for their own continued professional learning and development; information required for needs assessment and practice in general would be sought through reading, questioning etc.
observation data wide diversity of different situations observed, in terms of both client needs and working practices. breadth of knowledge used (see theme 4)		
curriculum document DN modules: emphasis on autonomous specialist practice (p209) and becoming a competent practitioner in community setting (p216). HV modules - overall aims to promote ability to critically appraise own work, begin to develop professional artistry and determine own professional role and responsibilities (p98); presumption of continued development after qualifying (p113).		

CASE M; THEME: 8
THE REALITY OF PRACTICE

Commentary	Educational implications
Neither clinical supervsion nor preceptorship featured highly in the data, with only one practitioner mentioning the latter, and none appearing to receive the former. The extreme variability in working situations, in terms of the extent of support which might be available from immediate colleagues to newly qualified practitioners, has long been the subject of anecdote, but it does not seem to have been fully researched at all. As in theme 5, the importance of practice experience during the programme of preparation appeared highly relevant, with the quality of supervision again being highlighted. The period of supervised practice was singled out as an important time for practising the skills needed to enable the practitioner to move forward confidently as a newly qualified specialist, even if good peer support was not immediately available in the workplace. In this case study site, one major difference between the health visiting and district nurse specialist course modules, related to the extent of emphasis placed on personal, professional development. While the district nurse curriculum specified that practitioners were learning to be autonomous specialists, none of the course content appeared to be specifically directed at achieving this. However, the importance attached to developing skills of self-directed, continuing professional development was evident in the health visiting curriculum, and supported by a specific programme of reflective learning.	Preparation for such variability in the practice situation must involve true 'education' (as opposed to mere 'training') since - once qualified - the practitioner may not be employed a 'protected' situation for even a short period of time. The idea of 'self-directed learning' needs to blend into 'self-directed practice' with practitioners fully aware of the need to find for themselves, answers to problems or client needs. The supervised practice period undertaken by these practitioners appeared useful in this regard, as it allowed them to begin to develop a repertoire of assessment skills and to test out their knowledge. It is a source of concern, therefore, that this period of practice does not feature as a compulsory element of the new PREP programmes (UKCC 1994).

Case 'N'

The Trusts served by this educational institution are located in communities which extend over widely contrasting populations, living in dense inner city and / or small isolated rural areas. Accordingly, participants were based in diverse settings, although common themes of high unemployment, and caseloads extending over large geographical areas, were common. People living in this area had been influenced by the slow demise of traditional forms of employment which had not been replaced by work in other forms.

Participants from the health visiting group were more difficult to obtain in this site, but once trust had been established with initial partipants during interview and observation, a process of "snowball sampling" occured. This lengthened the data collection period considerably, because participants were unlikely to practise in Trusts for which ethical approval had already been obtained.

The following table shows the numerical information pertinent to the sampling process:

CASE N	District Nurses:	Health Visitors:
Cohort size	21	16
Number contacted by researchers	21	16
Number agreeing to take part *	4	5
Final Sample	4	4
Number of Trusts	4	
Number of Ethics Committees	4	

The findings from the observation, interview and curriculae from case 'N' will now be presented in tabular form, according to the themes derived from the framework used in analysis.

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CASE N; THEME 1
CONCEPT OF NEED

Data examples	App 6N	Findings
interview themes	key	The impression was that need *in general* is viewed as a nursing issue. It is not considered possible to separate health and social needs, as they are too intertwined. Likewise, it is not considered possible to separate needs from the context in which they occur. Basic needs were seen as essential to survival where society's needs were concerned with social networks health and leisure. People's upbringing, the area in which they live, and environmental factors impacts on individual perceptions of need. Need was a multifaceted concept of varying levels, degrees, and dimensions, influenced by context, culture and gender. The context is both influenced by, and influences the way that needs are perceived by the client (eg, environment, culture, awareness) and the professional (needs may differ from one area to another; different 'official' agendas might influence perceptions). Cultural perceptions may influence professional views as well as clients. Distinctions are made between what the client may want, and what services are prepared to offer. Expressed needs are more likely to be met, but not in all cases. Needs of an individual were viewed in turn as part of the community - integral to each other, not only individual also a group whether that group be a family, a community or a population.
need seen as context-bound:	8a	
• subtle, holistic, linked to personal perception and views	1a, 1b	
• perhaps discrepant views between client and professional	1a	
• linked with area - upbringing, environment, culture	1a, 1b	
• linked with services and resources available	1b	
• health and social needs not separable	1a, 1b	
• multi-faceted; influenced by culture, context,gender	1a	
• varying levels, degrees, dimensions - family, generations	2b	
contradictory/paradoxical aspects of need:		
• distinction drawn between 'basic needs' (essential to individual survival) and society's needs (leisure, social networks etc)	1b	
• it is not always apparent or necessarily expressed - may be recognised intuitively or not recognised (eg abnormal behaviour)	1a	
• it may be more readily recognised/acknowledged if high on public agenda; comparative needs	1a	
• it may be obvious, eg poverty, smoking, profound needs	1b	
• it may be simple or complex; often multiple aspects	1a	
• it may be unpredictable or a source of uncertainty	1b, 8a	
• need and want may differ; definitions change	1b	
• service provision may follow documented need, or not	1b	
observation data The majority of practitioners demonstrated an awareness of client need on the wider context, mainly in terms of family members and carers.		
documentation		

CASE N; THEME: 1

CONCEPT OF NEED

Commentary	Educational implications
The concept of need did not appear to be an explicit element in the course. Major theories of need were addressed across many subjects, such as nursing theory, psychology, policy, law and health promotion. A strong emphasis was reported on the social, political and economic dimensions of need. In the data, the concept of need was only expressed in context, rather than as a separate, abstract idea. The sample was too small to draw conclusions, but there was an impression that the practitioners conceptualised need in a way that reflected their different roles and responsiblities, in the context of health visiting and district nursing. District nurses were primarily associated with individual clients needs and had little dealings with need at a collective level. Therefore, their clients' needs were dealt with in a responsive way rather than proactively; a study by Worth et al (1995) also found that pressure of work and demands on time limited the perceived utility searching out health needs. The work of health visitors seemed more likely to enable them to work at both an individual and a collective level. They indicated a wish to balance their work in meeting the expressed needs of clients and meeting the needs determined by the health visiting service. Both sets of practitioners acknowledged pressures and paradoxes in the need to balance the different attitudes and implications surrounding the notion of 'need'.	While acknowledging the constraints of practice, it seems important for students to have a sound frame of reference about 'need' which is not context bound. Unless they have a clear theoretical basis from which to draw, it seems unlikely that they will be able to transcend the immediate pressures of practice, or develop an understanding of alternative approaches to the assessment of need. Teaching about need across many courses may help to integrate the notion into all aspects of practice, but it may also militate against students developing a clear idea of what the concept actually means.

CASE N; THEME 2
NEEDS ASSESSMENT

Data examples	App 6N	Findings
interview themes	key	Assessment was viewed as a holistic concept, defined as the whole basis of visiting. All visits to clients were seen as assessments; each was considered different and individual. Assessment was more than just for the purpose of instrumentation but the orchestration of a persons needs. Practitioners were responsible for composing and arranging the different elements of the assessment. Assessment was seen as a purposeful activity concerned with intervention, and linked to provision, otherwise assessment would be meaningless. However, assessment appears continuing in nature, with reappraisal inherent in its nature. It may be informal and not always overtly explicit. Carers required the same ongoing assessment process as the client, especially in a complex family situation where the dynamics of an extended family seemed relevant. Clients need were fundamental to the assessment but resources were still likely to determine assessment in being linked to service provision. Determining the capacity to help an individual required a degree of judgement in balancing want and professional judgement. Assessment was very much concerned with the ability to address need; it was perceived as being about offering choice and alternatives but in doing so practitioners had to consider what services were available. Assessments were not just for the purpose of gathering information, but involved education. Much of the skill of assessment was perceived as lying in the ability to achieve a positive balance between multiple, sometimes conflicting aspects of needs and different approaches to assessment (structured, unstructured etc).
assessment as		
• purposeful: linked to service provision;	1a, 8a	
• documentation: differs according to service and situation	1a, 2b, 8a	
• structured; use of models; framework; objective; focus	1a, 8a	
• meeting specific needs (carers, families, child protection)	1a, 2a, 8a	
assessment as		
• about individual; family; group - each of them as a whole	8a	
• whole basis of practice; ongoing process	8a	
• forming relationships; interaction and communication	2a, 2b	
• intuitive, unstructured; 'mental list in the mind'	8a	
• professional judgement; decision making	2b	
• opportunity for choice, negotiation, client involvement, self-assessment and education	2b, 8a, 10 3a	
assessment as a source of conflict:		
• dilemmas between client/carer; collusion (eg about diagnosis)	2b	
• dilemmas where choices not available (eg 'ideal' not achievable, identified need cannot be met)	2b,2a	
• resource constraints; prioritising	1B,2b,8a	
• ethical issues;confidentiality	2b	
observation data A minority of both HV and DN visits were first assessments, though follow-up was nearly always arranged, which suggests continuity was a valued concept of professional practice.		
documentation More DNs than HVs worked with structured, standard records, which were completed during the visit and included physiological measures. HVs tended to complete records at the clinic, the few structured measurements documented reflecting chilkd growth measures		

CASE N; THEME: 2 **NEEDS ASSESSMENT**	
Commentary	**Educational Implications**
Two practitioners in this site had prior qualifications in community nursing (district nursing and school nursing), but all expressed havy dependence on their previous education, training and experience. This may point to the importance of practice experience in developing needs assessment skills, since they are essentially practical in nature. This continuity may also contribute to the idea of needs assessment as an holistic activity, being rooted in nurse education and socialisation. Skills were thought to be acquired through learning by example and experience, with little recollection of teaching in College. Although the interest, quality and motivation of the community practice teachers seemed crucial, not all were found to be good in practice, or in the providing and supervising appropriate or effective learning. At the same time, there seems to be a largely unmet requirement for practitioners to develop a sound knowledge base from which to practice the skills of assessment. Specific issues such as child development, continence assessment and pressure area care were mentioned in relation to purposeful and structured assessments, while the importance of a client centred approach and what were termed 'counselling skills' were cited for obtaining information, especially in unstructured or intuitive assessments. The relevance of legal, ethical and policy related dimensions were acknowledged, but learning about these elements did not really make sense until they were used and developed in the practice setting, leaving some practitioners with a sense of vulnerability or inadequacy when first qualified.	There is clearly a need to develop practitioners' theoretical knowledge about the range of potential needs they may be asked to assess. The analysis suggests that much of this knowledge is required before the practitioners can be expected to develop the assessment skills they need for practice. However, the importance of developing these skills through practice appears crucial, as does the presence of expert role models who are able to facilitate good learning opportunities. The ability to draw creatively from a range of practical skills and theoretical knowledge according to the particular assessment situation requires a level of 'professional artistry' (Schon 1983), which cannot be readily observed. Learning will be best facilitated by teachers who can confidently articulate their own practice, then constructively and reflectively 'debrief' students after their early assessment experiences (Fish et al 1991).

CASE N; THEME 3
WORKING AND SHARING WITH CLIENTS

Data examples	App 6N	Findings
interview themes	key	Whether a client centred approach was achievable was largely determined by the purpose of assessment. Some assessments were felt to be wholly client led but others required structure particularly where clients were not aware of their need. Undertaking assessment was seen as impossible in one visit as the initial assessment only serves as an 'entry behaviour' with some clients. Some clients need time to absorb information, to learn, adopt and adapt to a change in health status. In view of this, assessments were partly viewed as an opportunity for education; informing and enabling clients to develop the skills to cope. Interview data suggested thayt the process of filling in one's own records was seen as helpful. Clients recording information about themselves was considered more accurate as clients not under pressure to answer practitioner led questions. It was considered more like joint care due to patient involvement and where patients may be more co-operative. One of the outcomes of self assessment was seen as creating a different relationship with patient in giving patients a say in their care. The idea of 'self assessment' was drawn from practitioners experience of this approach in themanagement of pain in palliative care. Additionally it was reported as helpful by some health visitors when used to assess depression in post natal mothers. However, observation data suggested this ideal was not practised widely. Although DNs completed documentation in the client's presence, HVs tended not even to allow clients to hold records, and to complete these at the clinic.
as an attitude		
• being non-judgemental	2b, 3a	
• recognising different perceptions of need	1a 1b 3a 3b	
• about listening and sharing; partnership	2b, 3a	
• openness, honesty, respect	2a, 3a	
• giving responsibility back to patients	2b	
about educating:		
• if needs not recognised by client	1a	
• time for clients to take things on board	8a	
• enable clients to decide for themselves	2a	
• encourage self-assessment	3a	
part played by documentation:		
• parent held records	3a, 10	
• records left in clients home	3b	
• encouraging clients to complete records; enables joint care/patient involvement, encourages openness, develops confidence	3a, 3b 10	
dilemmas arising:		
• in child protection	2a, 10	
• different knowledge base between client/carer (eg about diagnosis)	2b	
• issue of confidentiality	2a	
observation data In nearly all instances, practitioners appeared to recognize the client's view of need and discuss the service definition, which resulted in negotiated agreement. DNs, more than HVs, found clients sometimes reluctant to discuss particular needs, though these instances were largely acknowledged in subsequent interactions (eg information giving). There was much evidence of client contribution by means of questions and suggstions.		
documentation		

CASE N; THEME: 3
WORKING AND SHARING WITH CLIENTS

Commentary	Educational implications
While the practitioners espoused a commitment to working and sharing with clients, this was not readily apparent in all the observations. The interview data hinted at some possible reasons for the discrepancy which may indicate a level of insight by the practitioners into the constraints imposed by the context of their practice. Equally, they may be unaware that their practice is less participative than they would like it to be; Kendall (1993) found that health visitors simultaneously espoused an enabling, participative style, while working from their own, rather than their clients' agendas. Nevertheless, the cited dilemmas arising in practice appear very real and readily recognisable. Notions of openness and confidentiality are never straightforward and they become more complex whether the family is regarded as 'the client' and assessed as a whole, or if the individual needs of carers, children, parents and other household members are considered separately (Clark 1986, Nolan and Caldock 1996, Orr 1992a). Overcoming these potential dilemmas in assessment may involve lengthy involvement and input, pointing once more to the way that needs assessment is intimately interlinked with the rest of the work.	The first step towards openly and honestly working adopting a client centred approach may be the acquisition of suitable, non-judgemental and accepting attitudes. . However, the data made clear that additional skills and knowledge are required to deal with the dilemmas which may arise, either from the family and social context of the client, or from pressure to meet service requirements which may conflict with client preceptions of need. Handling basic ethical dilemmas about prioritising which particular needs should receive services may be taught in conjunction with caseload management. A good understanding of 'normal' family functioning and conflicts is required to fully appreciate how to carry out 'family nursing'.

CASE N; THEME 4
RESOURCES AND SERVICES AVAILABLE

Data examples	App 6N	Findings
interview themes	key	Understanding of formal NHS and social service provision alone was not sufficient to inform needs assessment. Instead, knowledge was needed of a wide diversity of different potential services, run by private, voluntary and charitable sources The use of welfare benefits to pay for some of these services was a feature. The importance of understanding which services may be available was apparent, not only because they may help to meet assessed needs but also because awareness of a lack of services might structure the assessment. Interview data suggested that being honest and open with clients whose identified needs could not be met might mean facing disappointment or anger, although resigned acceptance and understanding also featured. Conversely, knowing which services were available and how to access them, might help improve provision for the client. However, sharing information about both provision and its limitations was not always in evidence in practice Resource constraints, and the associated dilemmas in practice, appeared to pervade the data and understanding of both 'need' and 'needs assessment'
Resources available		
• mixed economy of care; welfare allowances, private care, voluntary services, charitable provision	4a, 4b	
• service availability more influential than assessed need	4b	
• needs and resources: consider together	1a 4b	
• working with insufficient resources; prioritising need	2b 8a	
Dilemmas		
• rationing; making judgements	4b	
• perceived gaps in services; reductions in services	4b, 4a	
• unmet need: uncover needs which cannot be met	4a	
• fitting needs to services	1a, 4b	
• wants and needs (client views vs professional views)	2b	
• coping with clients with unmet needs: their acceptance, or frustration	4b	
Access		
• procedures to access services; knowing who to go to; different rules in different areas	4b	
• 'filling the gaps'	4b	
• creating and seeking responsive services	4b	
observation data In all but a few instances, information was provided by professionals on NHS provision and the suggested service response to identified need. However, information related to other services (eg social services, nursery provision) was less in evidence and areas of need which could not be met were only once noted (in relation to transport).		
documentation		

CASE N; THEME: 4
RESOURCES AND SERVICES AVAILABLE

Commentary	Educational implications
This theme suggested three linked issues. The first, which pervaded much of the data, related to difficulties arising from a shortage of resources to meet assessed needs. The other two could be seen as encapsulating the ways practitioners made sense of the situation (by understanding how policies and responsibilities for service provision were operationalised within the local context) and how they sought to improve, or at least 'make the best of things', with varying degrees of success. There is little research evidence to contradict the 'official' government view that there are adequate resources, if they were only used adequately. Much current literature seeks to explain resource dilemmas in terms of unclear professional boundaries or confusion about service responsibilities, suggesting that clarification is the major issue. Whatever the 'truth' of the matter, the practitioners need preparing to work within a system which enables them to practice in a way that reduces their own dissonance and frustration, by achieving as much as they can on behalf of clients whose needs they have assessed.	This theme points once more to the different but linked requirements from theoretical and practice teaching. The ability to understand the complexities of the mixed economy of care, and the policies through which it was created, is essentially theory based. However, to be of practical use, this knowledge needed to be applied within the local context. The skills to access and make good use of the diverse services which might be available in certain circumstances requires an ability to act as advocate for the client. It may be necessary to 'work up the referral' (Luker and Chalmers 1989) with both client and receiving service; these skills are best practised in a 'real' setting, since they involve both personal contact and networking ability. Also, some personal professional development may be required for the ability to cope with the potential anger, either expressed by clients or experienced by practitioners themselves, in response to the frustration of unmet needs.

CASE N; THEME 5
COLLECTIVE NEEDS ASSESSMENT

Data examples	App 6N	Findings
interview themes Profile types: • different levels - caseload; general practice; ward; neighbourhood; locality; trust • of health needs; of work carried out • audit of specific needs (pressure sores, incontinence) Approaches used • management: practitioners not involved • practitioner working alone: no sharing • combined/joint profile with other professionals • primary health care model • formal, informal, intuitive • unco-ordinated in reality • clients not involved Reasons given for compiling profile • as coursework • raise awareness of needs; insight into actual health needs • to inform work, especially health promotion; • to prioritise • to plan work • part of HV marketing strategy	key all 5a and 5b	Assessment of need at the wider level was explained in a variety of ways, at different levels and with different degrees of collaboration between professionals; the 'reality' was perceived as generally unco-ordinated. Profiles of work carried out was linked with health needs profiling; often 'caseload numbers' were all that were required. There was some suggestion that identifying unmet needs too carefully might create difficulties, because of a lack of resources to meet the needs. Formal approaches involved quantifying conditions, levels of diagnosed illness and disability using statistical data (eg from public health report). Informal approaches involved practitioners doing profiles on their own case loads, combining intuitive and formal, findings perceived as rooted in reality. 'Intuitive profiles' were so called when health needs existed within case loads so were known by practitioner (eg youth needs, single young mothers, smoking, mental illness, social conditions, young disabled living alone). However, no apparent attempt had been made in these situations to check these perceptions against formal data relating to the local people who might not have come to the notice of the practitioner.
observation data There was no observation data on collective needs assessment.		
documentation		

CASE N; THEME: 5

COLLECTIVE NEEDS ASSESSMENT

Commentary	**Educational implications**
There was little evidence to suggest that practitioners, especially district nurses, were actually involved in completing profiles to assess the needs on their own caseloads. As indicated by Worth et al (1995), responding to needs which were immediately apparent and already on the nurses' caseloads seemed overwhelming and there was little support for the idea of seeking any other hidden or unmet needs. The mismatch of data available at ward level with the nurses' caselists was also noted (as in Chase and Davies 1991, Young and Haynes 1993). Managers appeared mainly to be interested in profiles of work completed, so this was the priority for data collection. There was also a suggestion that profiling might be a management task, rather than a practitioner activity. No apparent links were made between the different levels of data about need (ie, between individual or collective/population levels) or between the different professionals and services, who were each seen to collect their own needs related data separately. Overall, the full potential of profiles of health needs to the everyday work of community nursing appears to have been largely unrecognised and unfulfilled in this case study site. Having said that, there was some limited understanding of the way that profiles could contribute to health promotion and help to prioritise and plan work.	The major priority in this case study site seemed to be on 'getting the work' done reactively, rather than planning or prioritising through caseload profiling. It may be appropriate, therefore, to link teaching about caseload profiles and collective needs assessment with sessions about caseload management.

CASE N; THEME 6
MULTIDISCIPLINARY AND INTERAGENCY WORKING

Data examples	App 6N	Findings
interview themes working with social workers • for child protection: complex, formal assessment • link is through making referrals • joint assessments not supported by structure • lack of formal collaboration between agencies • lack of informal collaboration between agencies • duplication and lack of communication working with GPs • opportunistic liaison; work closely • receiving referrals from GPs • 'distant'; lack co-operative approach • perceived loss of autonomy barriers to joint working • different - approaches; viewpoints; priorities; expectations • perceived lack of respect (from social workers and GPs) • waiting lists for assessment	key all 6a and 6b	In the interviews, the idea of 'working together' was broadly supported, but no joint assessments (social and health services) were seen, and practitioners appeared to have little experience of this actually happening in practice. Health visitors explained about links forged in child protection cases, when assessments tended to be formal and complex; these might start with a referral situation. Some district nurses suggested that joint assessments (ie, under NHS & Community Care Act) were not supported by management action. Frustration was expressed about the way assessments were carried out, pointing to the existence of waiting lists and reluctance on the part of agencies to accept responsibility for client care. The 'separation' of working practices was attributed to a lack of management commitment to bridging the division, to poor communication between agencies and individuals, and to a perceived lack of respect for the professional judgement ofcommunity nurses. These appeared to be present in some instances between GPs and community nurses as well, but in other cases, communication was viewed as easier, especially where geographical location eased communication.
observation data Where referral came from outside agencies, the majority were from GPs (especially for DNs) with some contact with hospitals, midwifery & social services evident. There was some evidence of practitioners informing clients about accessing other professionals and these included Macmillan, home care and OT services (DNs) and GPs, psychologists, social workers, housing and clinics (HVs).		
curriculum documentat DN & HV taught together in common core, but not with SW or medical students		

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CASE N; THEME: 6
MULTIDISCIPLINARY AND INTERAGENCY WORKING

Commentary	Educational implications
There was a sense of frustration in this theme, stemming from two major sources. In the first instance, many of the nurses considered that their skills in needs assessment had been undermined because social services had the 'official' lead for assessment under the NHS and Community Care Act, 1990. Most clients were deemed to have *either* mainly social *or* mainly health needs. In practice, some of the district nurses considered that they had a contribution to make to social needs too; however this was not acknowledged officially, and most felt they had little responsibility for needs assessment under the Act. Furthermore, the primacy of social work assessments in cases of complex need was considered to lead to duplication, rather than to improve interagency communication. The second source of frustration stemmed from the impersonal nature of communication between different professionals, notably social workers and community nurses. This was considered to be largely due to management disinterest in establishing effective links; it was exceptional for individual practitioners from different disciplines to know one another personally. Joint working between general practitioners and community nurses was sometimes improved by this personal connection, especially where geographical closeness and negotiation regarding referrals improved communication. Some expressed concern at a perceived loss of autonomy created by GP fundholding, with its associated emphasis on cost containment. While the practitioners spoke positively about the ideal of multidisciplinary and interagency working, there was little sense from the practitioners that they felt able to have any personal influence, or take responsibility as individuals for improving the poor communications which they recognised in practice.	Experience of interdisciplinary training at a trust level reported by participants was viewed positively and productively. Sharing the education forum with professionals directly associated in their day to day working situations helped to facilitate working together and address the 'invisibility' of social workers who were otherwise not seen as people - just regarded as 'social services'. In view of this experience, the practitioners themselves identified the importance of shared learning between disciplines in college. Benefits to being educated together were seen as providing a greater understanding of the focus of other professionals' work, facilitating an attitude change, and an ability to marry up the health and social split. Working jointly and being educated jointly would be supportive, informative, and helpful in enabling professionals to share skills which complement each others work. There is considerable support for these ideas, in a wide literature about joint education and training (eg Barr 1994, Carpenter et al 1995, Davidson and Lucus 1995, Shaw 1993). Another educational issue, however, is the extent to which specialist community nurses should expect to remain 'at the mercy' of colleagues, purchasers and managers, or whether they should take responsibility for addressing problems they encounter in practice. There appears to be a need for practitioners to learn appropriate assertiveness skills, and to be be able to think creatively and flexibly about improving their own ways of working.

CASE N; THEME 7
COMMUNITY CARE ACT

Data examples	**App 6N**	**Findings**
interview themes	key	The practitioners seemed to remember learning little specifically about the NHS and Community Care Act in College, although they did recall having lecture sessions. Once in practice, it became more meaningful. Much of the philosophy associated with the Community Care Act was perceived as applying to other aspects of their work (eg, joint working, learning about needs of a particular family). However, the philosophy was not always translated into reality; communication difficulties continued, especially about arrangements for discharge from hospital. Difficulty in meeting patients' expectations because of a lack of resources, was a source of concern; practitioners cited the importance of being honest about which options are available and involving clients in making choices. The district nursing service had recently begun to develop some specific plans to engage in care management. Resentment was expressed about the apparent power wielded by some social workers, who might delegate work to district nurses rather than involve them in initial assessments. This was perceived as restrictive, preventing holistic assessments. Accordingly, some district nurses welcomed the additional responsibility, 'clout' and satisfaction associated with care management, but others expressed concern about meeting other caseload demands while coping with a potentially increased workload from care management.
Understanding of Community Care Act		
• about joint working, multidisciplinary approach; working with social services, team approach	7b 7a, 7b	
• about matching services to needs; taking account of carers needs	8b 7a	
• not related to health visiting work	7a	
• about longer, more formal documentation and assessment	7a 8b	
Care management	all 8b	
• ideal: one care manager or key worker		
• documentation perceived as rigid, restrictive		
• social workers usually seen as care manager		
• shift towards district nurses as care managers (only in some cases, eg, terminal illness)		
• district nursing role: monitor, co-ordinate, assess		
• especially useful for people with most complex needs		
Potential for conflict and change		
• social workers perceived as unable to assess health needs		
• district nurses feel able to assess social needs; not part of their formal role		
• lack of resources to meet assessed needs		
• focus on organisational provision, not assessing needs		
• could enhance district nurse role - non medical approach; team leader role		
observation data No observation data related directly to his theme.		
documentation		

CASE N; THEME: 7
COMMUNITY CARE ACT

Commentary	Educational implications
Much of the understanding in this theme is linked with the idea of joint working, as developed in Theme 6. However, not all practitioners had made this link, with one even remaining unaware of any connections between needs assessment, care management and the Community Care Act. While health visitors generally considered the Act was little related to their work, district nurses had recently begun to grasp the nettle of care management. Care management was viewed as a new phenomenon for district nursing. Care managers had previously been social workers, with district nurses playing a marginal role in needs assessment. Their new role in care management does not appear significantly different, as social workers delegate clients to them for care management. The district nursing role and responsibilities were considered to be for monitoring and re-assessment; not of primary assessor. Exceptions to this appear to be evolving with clients who are terminally ill and whose needs predominantly require district nursing intervention. The Audit Commission Report (1992), too, found 'an assumption' among social workers that care manager equals 'social worker'; they suggest that nurses are well placed to take on the role of care manager. The importance of the practice situation in consolidating any learning which takes place in college is highlighted once more in this theme. In general, the practitioners did not feel they had understood the teaching in College, until they had encountered care management or joint complex needs assessment in practice.	Theme 2 highlighted that it seems difficult for students to really understand the notions of 'need' and 'needs assessment' because the topics are so highly integrated with the whole experience of learning to be a community nurse. Similarly, it seemed difficult fot the community nurses to really differentiate all the requirements and expectations attendant on the Community Care Act from their everyday work. While the idea of 'care management' was clearly distinguished, the understanding came mainly from post-qualifying experience rather than learning on the course. The importance of learning in and through practice, and the difficulty of students obtaining experience of these complex assessments during the course may need to be addressed through educational contracts.

CASE N; THEME 8 **LEARNING TO ASSESS NEEDS**		
Data examples	**App 6N**	**Findings**
interview themes	key	Fieldwork (taught and supervised practice) was perceived as essential in learning how to combine the theory into a meaningful assessment. Theory was essentially seen as being just about 'putting a label' on what had been learnt, whereas practice enabled learning about what it really meant. The community practice teachers appeared especially significant as role models. The complexity and breadth of the subject matter was compounded for some, by their own feelings of vulnerability raised during discussions of sensitive issues; the communications/counselling module was singled out as a painful period. Once in practice, it became necessary to face up to various dilemmas and difficulties stemming from ethical, interdisciplinary or resource-limitation concerns. The emotional preparation for coping with such difficulties was thus seen as a major issue. Two health visitors had previously worked as community nurses (district nurse and school nurse) and this was seen as a great benefit in helping them to make the transition.
learning about need		
• learn about health first	1a	
• nursing models: Orem, Roper; Neuman (for families);	1a	
family visiting, nursing	2a	
• other theories mentioned: Maslow, Bradshaw, principles	1a 1b 8a	
of health visiting, Maxwell	9	
learning about partnership		
• parent held records; specific situations - child abuse;	2a	
understanding legal requirements; confidentiality	2b	
• about enhancing clients' confidence	2a	
• about multidisciplinary working	6a 6b	
• importance of practice teacher/role model	9	
developing skills and abilities		
• learn to look at whole family and their environment	8a	
• specific knowledge: eg, Community Care Act, child surveillance/development, vulnerability	7a, 8a	
• credibility of some course lecturers low	7a	
• most learning occurred in taught or supervisedpractice	4b 8a	
• facing dilemmas in practice: ethics, resource limitations	4a 4b 8a	
• value of prior experience	9	
observation data Observation data did not lend itself to this theme		
documentation		

CASE N; THEME: 8
LEARNING TO ASSESS NEEDS

Commentary	**Educational implications**
The distress experienced by some students in developing their interpersonal skills, and their sense of vulnerability as they qualified and took up new responsibilities, perhaps highlight the extent of professional and personal maturity required for community nursing. While the formal, theoretical base was acknowledged as essential, it did not become fully meaningful until utilised in practice. Purely theoretical approaches about each separate element do not help to resolve dilemmas or reduce the emotional stress associated with issues such as prioritising during periods of resource constraint, or coping with child protection or terminal care. The lack of practice credibility of some college lecturers was highlighted in this site; in general the practice teachers were regarded very highly. The ideas of 'self-help' and 'mutual support' recurred throughout the data, but there was an almost resentful sense that this had been incidental, rather than a valuable part of the course of preparation. Given the variability of post-qualifying support available, such activities may need highlighting as a positive expectation, so that students develop skills of seeking, developing and maintaining their own support systems.	The use of the different aspects of the varied theoretical base learned on the course needs to be demonstrated in practice by a skilled teacher and role model. This requires an ability on the part of practitioners to articulate their own activities and relate it to the relevant theory. Given the apparently limited opportunities for practitioners to obtain first hand experience of some important aspects of practice, it may be helpful if seminars and group discussions are held in College to capitalise on the limited opportunities which are available. If such seminars were jointly facilitated by practice teachers and college lecturers, this would help to overcome the 'credibility gap' suffered by some college lecturers - partly by enhancing their knowledge of the new conditions in practice. However, there would be a resource issue, since the geographical area covered by this college was very wide, and employers may not be prepared to release community practice teachers to contribute to a training course serving students from other Trusts . The expectation that students should demonstrate an ability to develop mutually supportive links could readily be incorporated within learning contracts and/or outcomes.

Case 'P'

The educational institution was situated in a large geographical region, covering rural, semi-rural, market towns, and moderately sized cities. The study sample practised in extremely varied setting, both geographically and organisationally, although there were few cultural and ethnic minority groups served. The local approach to GP fundholding was mixed, and employment arrangements for community nurses were varied.

People living in the region were heavily influenced by seasonal influences on business and employment and recent large reductions to workforce by a major employer in the area. The area drew in a number of travelling families, which some participants regarded as an important part of their work.

Some sample attrition occured because potential participants were unable to acquire posts in community nursing following qualification. Two of these people went on to take work which did not require their recent professional training.

The following table shows the numerical information pertinent to the sampling process:

CASE P	District Nurses:	Health Visitors:
Cohort size	10	11
Number contacted by researchers	5	7
Number agreeing to take part	5	7
Final Sample	4	4
Number of Trusts	4	
Number of Ethics Committees	4	

The findings from the observation, interview and curriculae from case 'P' will now be presented in tabular form, according to the themes derived from the framework used in analysis.

Category: Concept of need - definitions and perceptions (1)	Case study site: P
Data examples	Findings
Interview themes (see Appendix 6P1) Need as changeable. Need as professionally defined & client defined. Need as negotiable. Need as context bound Need as measurable. Need as hidden & overt. Need as complex. Need as based on deficits & strengths. Need and educational preparation and guidance.	Definitions and perceptions of need put forward by practitioners spanned a professional/client orientation. Similarly, need was seen as both measurable & nebulous and based on strengths & deficits. However, there was a strong emphasis on need as changeable, context-bound and at least partially hidden. There was little linking made between the concept of need and formal educational input volunteered by the community nurses other than mention of need in college as context bound by one practitioner (DN4). HV3 and DN2 felt the issue was dealt with superficially and HV4 and DN2 proffered alternative sources of learning about need (reading, supervised practice).
Observation data Half of the HVs and DNs commented on the wider effect of a particular individual's need (ie context), though this mainly related to the individual him/herself and the family, with only 3 (2 DNs, 1 HV) referring to the wider network.	
Documentation data The only explicit mention of need as a subject addressed in the programme of studies appeared in the sociology/social policy module in the context of "needs, wants and duties" (vol.3 p.69)	

Category: Concept of need - definitions and perceptions (2)	Case study site: P
Commentary	Educational implications
An awareness of the dual nature of need which emerged from the focus group data is illustrated well. The notion of need being conceptualized from a professional viewpoint and also being identifiable by the client is compatible with the literature (Chalmers, 1993, Bradshaw, 1972), while Chalmers also noted the hidden nature of need, implied here, where professionals encourage clients to open up. The context as an influence on need (eg presence of carers) is mentioned by Ong (1991). There is obviously a limit on the extent to which observation can yield information on an abstract concept, so the paucity of data here is not surprising. Similarly, lack of explicit mention in the curiculum does not mean it was not integrated within other modules and lack of recall does not necessarily mean lack of formal educational input. However, the fact that alternative sources of learning were mentioned, together with this evidence, supports the suggestion.	The question of how personal constructs of need arise is interesting and appears to have multiple bases. There may therefore be a need to address the issue of how best to support learning related to abstract but fundamental concepts in a more explicit way if confusion over responsibilities for subsequent assessment of those needs is to be avoided.

Category: Needs assessment - characteristics and purposes (1) Case study site: P

Data examples	Findings
Interview themes (see Appendix 6P2) Needs assessment as: an ongoing process, structured & unstructured, aiming to promote independence, covering health and social needs, carried out by one or more assessors, inclusive of specialist nursing assessments, having educational implications.	The only condition highlighted where needs assessment was not seen as an ongoing process was where it was a joint (interagency) activity. An unstructured or loose framework appeared to be used more when undertaking a general nursing/HV assessment, while a more structured format was more often used (and of value) for interagency working, specialist nursing asssessments, working under trust guidelines and assessments by inexperienced practitioners. Similarly, a holistic assessment seemed to predominate for nursing/HV assessments, with an emphasis on health, and a recognition that other disciplines have their own emphasis which might impinge on nursing/HV work(eg when called to to social service assessments). However, there was a marked inconsistency, and lack of clarity, regarding assessment formats even within the same discipline and case study site. Single, qualified DN/HV assessors were considered most appropriate for unidisciplinary assessment, while multidisciplinary assessment was seen to involve more than one assessor and not necessarily a qualified DN/HV. Insofar as there was any recall of the subject, needs assessment was taught largely within the assessment phase of nursing modules in college, though the HV curriculum suggests this was taught as a discrete subject.Much was learned from CPTs in the placement, from experience, trust guidelines, trust courses and reading. The teaching of ideals was thought to be important but could also be unrealistic.
Observation data There were no complete first assessment visits in the data set. 16 out of 20 DN, and 8 out of 11 HV visits resulted in planned follow-up. Most visits (DN & HV) were not first visits and all were carried out by a single practitioner. Length of visit averaged 30 mins (DN) and 45 mins (HV). Records varied from structured formats (DN wound, leg ulcer, diabetic assessments, HV weight, height, post natal depression scales) to blank sheets (DN for social services), to no documentation (predominantly HVs whose records were kept in the clinic).	
Documentation data One of the primary aims expressed in the curriculum document was for higher education and professional practice to "continuously inform and illuminate" each other (vol 1 p.3), facilitated through the fieldwork and supervised practice. Also, close links between college and CPTs/assessors have been developed in response to external examiners' reports. The HV programme is theoretically underpinned by an emphasis on searching for health needs, health assessment skills and need identification (vol 1 p.17). The DN programme's philosophy speaks of the development of expertise in assessing health needs of the individual (vol 1 p.20). However, although the HV syllabus specifically mentions assessment of need, screening and surveillance, there is no corresponding mention in the DN syllabus. Assessment documentation itself varied. Two DN bases had only social services (SS) and specialist (leg ulcer & continence) forms, one a (different) SS and a generic form, and one a (different again) SS form only.	

Category: Needs assessment - characteristics and purposes (2) Case study site: P	
Commentary	Educational implications
There appears to be a dichotomy beween the ongoing, holistic, intuitional professional nursing assessment, which leads to action, and the more formalized, specialist assessment requested by social services, which is an end in itself, as part of the official "Community Care". Education appears to lack a strong nursing base in this area, with the result that there was difficulty in linking theory (which dealt with assessment within abstract models and unfamiliar trust philosophies) and practice (illustrated, for instance, in the reference to the more tangible assessment requirements of social services). However, such models appear to be popular among nurses for needs assessment (Philp & Dunleavy, 1994) and this practice of "frontloading theory" in education, resulting in a theory-practice divide has been previously noted in research (Alderton et al, 1995). There is an ambivalent approach to the teaching of ideals rather than reality but an acknowledgement that teachers would have little experience to draw on, as community care was so new. There is also an ambivalence regarding whether HV/DN training is necessary for needs assessment; a variety of levels of simplicity/complexity are implied.	The obvious theory-practice gap here is not a new phenomenon (Hunt, 1987). While it is laudable that nursing models are being taught and used to guide practice generally, there would seem to be a need to link individual features of any model (in this case assessment) with contextual realities (in this case the climate of community care). Within the practice placements themselves, there would appear to be a need to rationalize assessment documentation in order to avoid confusion for students and newly qualified practitioners. Again, while the teaching of ideals would appear to be necessary, an awareness that they may not be readily translated into practice seems equally important as an educational issue in order to mitigate the effect of conflicting demands on practitioners. The timing of data collection perhaps means that the problem of little experiential knowledge on the part of tutors would be less of a problem with community care well established. Finally, the issue of levels of needs assessment linked to corresponding levels of professional education for this could be discussed further. Suggestions put forward by respondents for education for needs assessment (and linking theory to practice) include bringing CPTs into the college, bringing in experts from the field, group sharing of ideas and problems and instituting mechanisms for clinical supervision/ preceptorship. An awareness of the desirability of these is apparent in the curriculum, but has, perhaps, not been actualized. Similar mechanisms for improving links between education and practice have recently been implemented elsewhere (Davies et al, 1995), which suggests they are feasible.

Category: Individual/family needs assessment - dimensions and skills (1) Case study site: P

Data examples	Findings
Interview themes (see Appendix 6P3) Client and family focus Technical and prioritizing skills Interpersonal skills Nursing judgement and decision making Conflicts of interest Education for individual/family needs assessment	There appeared to be general support in the interview data for the idea that assessment encapsulates both individual and family dimensions (which itself is interesting in view of the apparent individualistic focus of the DN curriculum). Components of assessment for DNs were primarily seen in terms of standardized, pretested instruments (DN1), recording vital signs (DN2), ADLs
Observation data All DNs except 2 described "client" in terms of single individuals, while all HVs except one described a "family" of different compositions. Knowledge prior to visit was variable. Only 3 DNs introduced themselves specifically and stipulated the purpose of the visit; all HVs did so, even when this was not a first visit. However, all practitioners were thought to display "house rules" (examples in raw data). Regarding skills, some HV clients (but no DN clients) were reluctant to discuss areas of need, which practitioners responded to in various ways. Conversely, "blocking" by nurses was only noted to occur twice. Where knowledge was displayed, its nature was predominantly biological sciences (DN + HV), developmental (HV only), pathology (DN only) and pharmacy (DN only). No research, psychology or sociology based knowledge was noted. Communication comprised both open and closed, and social and procedural characteristics by both DNs and HVs.	(DN3) or observation linked to a knowledge of physiology (DN4). Two listed these as priority areas. For the HVs there was little mention of technical measurement other than for post natal depression (HV3), though others were observed. HV priorities tended to focus more on a client based, psychological agenda. Interpersonal skills were considered vital to needs assessment by all practitioners and a wide range was itemized. Two DNs put forward the additional ability to use these skills while carrying out the more "official" nursing tasks, to elicit needs. Use of interpersonal skills, however, often meant conflicts of interest were highlighted (either client/family or client/professional). As well as concrete skills, practitioners spoke of the existence of professional, sometimes intuitive, judgement in assessing needs. Though the value of practice and experience was emphasized for the acquisition of interpersonal skills, there was also an acknowledgement that theory was also important; the study of psychology was particularly
Documentation data The core diploma programme documentation incorporates a knowledge base including the biological/physiological sciences, psychology, sociology & social theory, organizational theory and research methods. Communication is documented as a constituent subject in the HV (but not DN) module. Individuals, families and groups are mentioned as a focus of HV. The DN syllabus, however, mentions needs only on an individual basis.	valued, though it needed to be at an appropriate depth and linked to practice. Interagency education for interpersonal skills was thought to be potentially useful.

Category: Individual/family needs assessment - dimensions and skills (2) Case study site: P	
Commentary	Educational implications
The notion that individuals cannot be assessed in the community apaprt from the family context has been put forward in the literature. The suggestion that this may give rise to client/professional or client/family conflict is supported in Twigg & Atkin's (1994) four model conceptualization of how professionals view carers; clearly family members occupy an ambivalent position in the health care system, dependent on any one practitioner's attitude to their status. Standardized, pretested instruments are recommended by Ross & B[illegible] (1995) and Williams et al (1994) for use in assessm[illegible]'s on the grounds that some degree of standardizati[illegible]es the potential for interagency working. Overall, interpersonal skills appeared to be well demonstrated. Good interpersonal communication and relationships also seem to underpin the concept of skills necessary for needs assessment put forward in the interviews, a view endorsed by the RCN (undated). The difference in "entry behaviour" noted between HVs and DNs is, perhaps, a reflection of greater frequency of DN visits and corresponding greater familiarity between practitioners and clients. Technical skills were also valued, as well as an intuitive element of professional judgement, less easily articulated, but originating in general nursing skills, rather then community nursing per se. This is somewhat akin to Benner's (1984) expert nurse. The community nurses here clearly feel in two minds as to whether such skills can best be learned through experience or educational preparation (or both).	Preparation appears to be necessary and highly valued in disciplines such as psychology (surprisingly, since this was not noted as being demonstrated in observation) which relate to developing interpersonal skills. Chalmers' (1993) work supports this, but suggests that comparatively little attention is paid to the theoretical basis for the processing of assessing interpersonal competence in training (compared to technical components which are emphasized in teaching). Certainly this seems to be reflected in the case study curriculum, where interpersonal skills are not explicit. Teaching also clearly needs to be of sufficient depth and firmly linked to practice. The idea of interagency teaching for communication skills has been tried elsewhere (Davidson & Lucas, 1995) and should perhaps be considered.

Category: Collective needs assessment - dimensions and skills (1) Case study site: P

Data examples	Findings
Interview themes (see Appendix 6P4) **Practice and caseload profiling** **Other levels of profiling** Purpose of collective needs assessment "Intuitive" profiling Conflicts/problems in collective needs assessment Education for collective needs assessment Observation data Since observation data pertained to individual needs assessment episodes, there was little of relevance to colective needs assessment. Documentation data The HV programme documented a focus on communities and groups and marketing as well as the need to make use of available data. The DN programme only mentioned needs assessment at the individual level. Both programmes stipulated a profiling exercise to be carried out in supervised practice as part of the overall assessment of practice. Assessment documentation only pertained to individual needs assessment.	There appeared to be minimal involvement in practice and caseload profiling by either DNs or HVs, according to the interview data. However, there was an appreciation of its potential value, and concrete examples were given of what this could show. Some individual practitioners were also beginning to take initiatives here. HVs tended to think of needs assessment primarily at this (collective) level. Recognition by practitioners, especially HVs, of other levels of profiling and of how caseload profiles fit in with the larger picture was apparent. There appeared to be a growing recognition of the purpose of profiles, in particular their usefulness in influencing service provision through acquiring resources and in giving an accurate overview of needs. Three practitioners (1 DN, 2HVs) displayed knowledge of "mental" profiles - familiarity with their caseload without detailing it as such. An awareness by some of the problems inherent in profiling included the inability to meet all needs identified, the temptation to keep all patients "on the books" ("just in case") and the fact that there exists general lack of understanding about what profiling entails, leading to resistance. Another issue brought up several times by DNs and HVs was the difficulty of carrying out profiles individually. All practitioners appeared to have completed a profile during educational preparation and this was in keeping with curriculum documentation. This was generally felt to be useful, however, guidance appears to have been inexplicit and the exercise was thought to be time consuming done on an individual basis. Other sources of learning were identified including reading matter and professional contacts with experienced colleagues. One DN felt information on profiling was too orientated to HV practice.

Category: Collective needs assessment - dimensions and skills (2)   Case study site: P

Commentary	Educational implications
Overall there appears to be a lack of involvement by practitioners in community assessment exercises and, though some awareness of its potential is demonstrated, this is limited. It is perhaps understandable that there is little DN involvement as the concept features little in the educational content identified in the curriculum documentation. The only mention - the profiling exercise which is a compulsory assessment - is not linked to the curriculum content and the rationale for its inclusion is therefore unclear. Some of the conflicts/problems mentioned by practitioners are highlighted in the literature. Worth et al (1995) have noted the way pressure of work for DNs militates against addressing unmet need satisfactorily, while Nocon (1993) comments on the duplication of assessment/profile data by different agencies and the lack of assessment/profile guidelines. This latter author, along with Boyd (1993), who writes of developments at Strelley NDU, and Wainwright (1994), who has participated in community development work, put forward practical suggestions for working together with communities and other agencies in identifying community needs, which can then facilitate appropriate targetting of resources (something overlooked by practitioner respondents here). Boyd (1993) also points to the need for a supportive management structure, to whom "profiled" needs can be taken, though Jacoby's work in the early 90s suggests that such information is (or at least was then) not utilized well.	The area of collective needs assessment would appear to be in need of emphasis in educational programmes, especially those for district nursing. Rationales for conducting profiles need to be made explicit and relevant to each discipline and its target client groups. Some of the problematical issues mentioned by respondents could perhaps be pre-empted through considering practical examples, either in the literature (as above) or through sharing practitioners' experience of successful profiling as mentioned by HV3. In particular it would appear useful to undetake profiling exercises in collaboration rather than individually. Practitioners also noted a lack of understanding of profiling by colleagues in practice, which may suggest a need for professional development here.

Category: Working and sharing with clients (1) - Case study site: P

Data examples	Findings
Interview themes (see Appendix 6P5) Seeking clients' views, perspectives and trust. Client advocacy. Conflicts and problems in client led assessment. Empowerment. Education for client-led assessment.	Both HVs and DNs expressed, at interview, the importance of eliciting clients' perceptions of their needs. A few took this further, suggesting an advocacy role, through representing clients' perceptions in carrying forward assessment into meeting needs. Additionally, three of the HVs emphasized empowerment in the identification and meeting of needs through the introduction of parent held records. However, a number of problems and conflicts in client-led assessment were identified by both DNs and HVs. These included the balancing of a "needs-led" philosophy with the realities of resource constraints, balancing the client's perceived needs with those of significant others (eg carers), the delicate area of child protection, where it may not be prudent to share all documentation openly and the possibility that, in expressing a need, clients may actually be exhibiting a form of denial, necessitating a professional lead in assessment. One HV felt that assessment was too much driven by the professional agenda, and that providers, at least at organizational level, were not interested in the client's view. Little was specifically said about education in this area, though one HV felt there was a lack of awareness of different cultures in the curriculum (which could help "get alongside" clients) and another appeared to have learned the principles which would inform a client led assessment from a subsequent course, not HV preparation. Observation data suggest that practitioners acknowledged a client perspective but did not always share with clients the professional viewpoint. Most client input (suggestions and questions) were self- initiated and practically based. Documentation tended not to emphasize the client perspective.
Observation data Only in a minority of HV or DN observed instances was there doubt that the client's view of need was recognized. On the other hand several DNs (but no HVs) failed to discuss the service definition or perspective and there was some evidence of a failure to allow the client to feed into a joint defintion of need. However, only isolated incidents of actual disagreement in perspectives seemed to occur. About half of DN and all of HV clients were observed to make suggestions, most of these being client initiated, rather than due to verbal or non-verbal prompting. The majority of clients were observed to ask questions, in the main, again client initiated. Most topics relating to client-centred interactions pertained to practical issues - for DNs pain, wound care/dressing, aids , social support and the like - for HVs screening, immunisation, "routine" checks, feeding etc. However, there were a few instances relating to a psychological/ support nature recorded.	
Documentation data The HV programme mentioned the importance of community participation in its outline. Other than this there was little in the curriculum to suggest a client centred philosophy. Only one of the assessment forms in use (a social services core assessment) included sections on how the client and carer viewed the situation, though one DN information leaflet for patients mentioned aims of empowerment, advocacy, informed choice and sharing documentation.	

Category: Working and sharing with clients (2)	Case study site: P
Commentary	Educational implications
One of the major tenets of the community care legislation is a client and needs led perspective, so it is, perhaps, not surprising that this featured strongly in the data. However, there was a slight mismatch in the pictures provided by interviews and observation. In the former practitioners expressed unanimously the desirability of sharing and empowering, while in the latter there was evidence of failure to "share" the service viewpoint or to provide verbal or non-verbal prompts to clients, and thereby promote a more equal power distribution. This contrasts with the findings of Kerkstra & Beemster (1994) who found that 88% of their sample, when practice was compared with a written nursing standard, discussed the expectations of commmunity nursing with the patient and his/her family. Findings here may, perhaps, be explained by the problems and conflicts mentioned by practitioners as inherent in a truly needs led practice and, possibly, by the apparent relative lack of client centred models found in either curriculum or assessment documentation. The first of these explanations is articulated by a number of authors (Wainwright, 1994, Caldock, 1993) though the second is somewhat surprising, since many of the ideals expressed by practitioners (advocacy, empowerment etc.) are also echoed in the literature (Caldock, 1993).	Several educational implications would seem to arise here. Although a lack of client centred teaching cannot be deduced from its omission from the curriculum, its specific inclusion may help focus the teaching philosophy. Caldock (1993) suggests that "teaching should focus on the way in which assessment can become a way for clients to analyze their problems and work out their own solutions". This is a difficult area for educationalists, since, judging from the data it will include dealing with conflict situations which are, by their nature, unique and difficult to prepare for. Teaching based on models of assessment and decision making (or standards as used by Kerkston & Beemster, 1994) may have something to offer here. For instance, McWalter et al (1994) clarify the concept of need, operationalizing it in terms of dependency and quality of life, which may be helpful in distinguishing its assessment from assessment for services. Another example which may be helpful is Beckingham & Baumann's (1990) model of family decison making, which may assist practitioners in empowering clients and families in identifying their own needs.

Category: Joint/collaborative/interagency working (1) Case study site: P	
Data examples	**Findings**
Interview themes (see Appendix 6P6) Advantages of interagency working. Referrals and contact between agencies. Intra-agency working (the nursing team). Problems of interagency working. Education for collaborative working.	Interview data suggest an appreciation of the benefits of interagency working, which included provision of services, getting feedback and gaining insight into the roles of a wide variety of professionals. However, there was not a focus on the interagency assessment required of the community care legislation. There were instances of regular contact meetings, especially with social services and much ad hoc referral. Observation data also suggest contact initiated by referrals - especially from GPs. Interviews point to some innovative practice, with practitioners initiating working together, although there was little evidence from the observations of any volunteering to clients of information about other agencies (unless they were already involved). For DNs teamwork with colleagues was an issue and there seemed general agreement that community staff nurses were capable of needs assessment, so long as there was an adequate supervisory mechanism. Interagency working could, however, be problematical. Difficulties included role demarcation over "grey" areas of health/social care, differing professional perspectives (various examples of this were given - see Table 6) and duplication/overlap in services. At the same time a certain optimism was evident that this situation would improve in time. Preparation for joint working through formal teaching on the subject and multidisciplinary education was primitive. Where it did exist it was considered useful and 2 HVs who had subsequently undertaken interdisciplinary child protection courses were particularly enthusiastic. One DN voiced concern about the emphasis on HV issues in the education programme.
Observation data Contact was made with other agencies through referral for assessment in a number of instances. For DNs this was mainly with GPs (4 occasions) or hospital (4), with some referral from practice nurses (2), social services and nurse specialists. For HVs referrals were mainly from GPs (8) with other sources including midwives, schools and clinics. There was little evidence of either DNs or HVs providing information for clients on accessing other professionals, services or organizations unless these were already involved in care. For DNs this concerned mainly information pertaining to the GP and medication.	
Documentation data The health studies modular scheme was aimed at "education for health care professionals in the broadest sense" (vol I p.5) and claimed to achieve this through core and specialist modules. Beyond certificate level, however, programmes were linked to specific nursing qualifications. Outcomes of the HV programme included cooperation with the primary health care team and colleagues and the ability to work as team members. The DN programme specifically mentioned the promotion of interprofessional learning as an aim and also mentioned the primary health care team and teamwork. Only one of the assessment documents specifically requested details of other agency input, though the DN information leaflet emphasized working with the primary health care team.	

Category: Joint/collaborative/multidisciplinary working (2) Case study site: P

Commentary	Educational implications
Contact with other disciplines appeared to occur mainly through referrals to or from professionals following assessment, or for unidisciplinary assessment, rather than for the joint assessment emphasized by the government (DoH, 1989a). The failure to develop joint assessment procedures is, however, not wholly surprising, since it reflects the national picture according to the community care monitoring rounds (NHSE/SSI, 1994, Henwood, 1995) and other research (Caldock, 1993, Worth et al, 1995). A failure to enquire whether patients are receiving care from other professionals was noted by Kerkstra & Beemster (1994), and this, perhaps, reflects the relative indifference displayed in the observation data to giving information about other services. This failure in information giving also suggests an inability to link conceptual elements of the assessment role, already embraced in the interview data, to its outworking - empowerment (see category 5), for instance, is denied where clients do not have the information on which to base self-referral decisions (Beckingham & Baumann, 1990). Teamwork is an issue for DNs, if not HVs, and a number of practitioners were obviously aware of skills related to delegation and accountability in assessment. This is an encouraging finding, though no specific mention of these skills appears to have been derived from the educational programme. Preparation itself appeared to have a "token" interprofessional emphasis through joint learning between HVs and DNs but there was little input from social services. Whether due to lack of awareness because of this, or other reasons, there was little evidence of contact in practice with social services, other than for specific issues (child protection for HVs, assessment for residential care for DNs). Hilton (1995) certainly suggests that such fragmentation in interprofessional work results from isolationism in health care professional education, while Caldock (1993) supports joint training as a means to resolving interagency problems.	Whether joint working is best promoted by preparatory education or in service is a matter for debate. Hilton's findings should perhaps be read alongside those of Bennett-Emslie and McIntosh (1995), who identify the single most important mechanism for promoting collaborative working as the practice meeting. At the very least it would seem beneficial to involve other professionals in the teaching of assessment - specifically social services personnel here to gain their perspective - and to include some multidisciplinary teaching - issues such as child protection will invariably involve this. Additionally, some direct input on dealing with different professional cultures may be helpful, in view of the lack of insight demonstrated by many of the respondents and Wilmot (1995) offers a way of considering some of the value differences between nurses and social workers, which should be acknowledged and used positively. Linking different areas of the curriculum, and concepts to practice, more explicitly (eg empowerment to interagency working) may help overcome the problems practitioners obviously had here. Skillmix, responsibility and accountability are issues which are pertinent to the preparation of DNs for delegating within the team, although there seemed to be little problem here in operationalizing them.

Category: Knowledge and provision of service response (1)	Case study site: P
Data examples	Findings
Interview themes (see Appendix 6P7) Accessing services and resources. Links between assessment and provision. Ethical issues. Education for service provision	One thing that comes over in the interview data is the influence extended by practitioners in accessing and ensuring appropriate resources - from the DN who blocked a patient's hospital discharge to the HVs looking at grant schemes, enlisting the support of MPs and councillors and seeing the potential of a vacant community hall. Observation data suggest this work was not, in the main, shared with clients in discussing provision. Practitioners clearly saw provision as a responsibility implicit in, and linked to, assessment, though this gave rise to situations of conflict where resources were clearly inadequate. This resulted in a certain degree of lack of control and to a need to ration care, though again, there was little discussion observed of this. There was a feeling that knowledge of service availability could only be learned within the clinical practice situation, since it varied from trust to trust. However, experience in alternative practice and an overview of nationally available services were felt to have the potential of raising awareness.
Observation data Only 4 out of 20 DNs, but all bar one HVs, were observed to provide details of NHS service provision, examples being chiropody, other DNs, stoma nurses, clinic services immunization programmes, midwives and post-natal groups. Fewer practitioners provided information regarding non-NHS services and these related to day centres and the like. About half DNs and more HVs made reference to the service response to be recommended, these comprising in the main the provision of aids and equipment and liaison with other professionals (DNs) and providing guidelines and tests (HVs). Two DNs and two HVs explicitly referred to the inability of the service to address needs articulated. These consisted of areas not covered by nursing/health visiting but by other professionals, items not on the drug tariff, school matters and changing feeding patterns.	
Documentation data The HV programme in the curriculum document identified as one outcome the ability to make efficient use of resources, but otherwise there was little explicit reference to this issue. Assessment documents usually included outcomes/action plans/objectives sections, which would imply a commitment to use of resources. Only one, however, referred specifically to the itemizing of equipment to be supplied and referrals made.	

<table>
<tr><th colspan="2">Category: Knowledge and provision of service response (2) Case study site: P</th></tr>
<tr><th>Commentary</th><th>Educational implications</th></tr>
<tr><td>The focus group data suggested that good needs assessment requires a knowledge of potentially available and suitable service responses (Cowley et al, 1995) and the proactive attitude of some of the research respondents here is thus commendable. However, the dual role of assessment and provision within the same practitioner, which was also implied, would seem to bring inherent problems. Certainly the government's guidance on the issue (SSI 1991) recommends separation of these two functions for this reason and the constraining force of limited provider resources on assessment is well documented in the literature (Chalmers, 1993, Bergen, 1995, Griffiths & Luker, 1995). Beckingham & Baumann ((1990) suggest that interventions need to be affordable and accessible as well as acceptable and appropriate, so it is perhaps not surprising that practitioners, in assessing needs, find it easier to think in terms of what is available, as McWalter et al (1994) noted. This obviously compromises a true needs-led assessment. Official guidelines also stress the importance of providing service information for consumers (SSI, 1991) in order to promote a client-led assessment process, which was not in evidence in the present research. This, perhaps, underlines the difficulty, and enormous cultural shift involved, in moving to a true needs driven perspective. This is obviously a difficult area to educate for, given the variety of service levels available locally and the individuality of the problems arising from this.</td><td>The issue of whether professional preparation should be contextualized or taught "context-free" arises here. Clearly it is necessary at least to prepare at a general level for coping with ethical problems, even if teaching related to a particular environment cannot be generalized to all settings.The potential for this to generate a theory-practice gap may be partially offset through the use of given local provision as examplers. One practitioner felt that teaching related to the "national potential" would also be helpful. Since respondents clearly learned much of their coping mechanisms in response to resource issues in practice, consideration should be given to supporting CPTs in helping students work through issues in the clinical setting.</td></tr>
</table>

Category: Community Care Act and political issues (1) Case study site: P	
Data examples	Findings
Interview themes (see Appendix 6P8) Impact of Community Care Act - structural and philosophical changes. Political issues - resource and ethical implications. Education for community care. Observation data Observation did not lend itself to useful data relating to this category. Documentation data The core modules of the Diploma in Health Studies listed sociology and social theory within its content, which is suggestive of coverage of political issues. However, the texts listed for indicative reading for the latter were pre 1989 and, therefore, predated the recent legislation (other lists mention later material). The HV programme itself mentioned policies affecting health, while the DN syllabus specifically referred to the NHS and Community Care Act and its implications. Assessment documentation provides indirect data as to the impact of the community care reforms through the inclusion of social services generated documentation requesting nursing assessments for residential care.	Most practitioners acknowledged at interview some impact of the community care reforms on assessment practices. To the DNs this tended to mean a closer working relationship with social services, a focus on needs and a push to separate assessment from provision. Assessment documentation also suggests a working together between social services and DNs. HVs tended to take a wider perspective, seeing community care as being primarily about moving care into a wider variety of settings, with the implications of a greater variety of assessments. However, the political changes also restricted assessment practices, largely due to constraints in terms of the consequent provision of services. The issue of raised expectations was a recurring one, though one HV suggested that, so far, clients perceived these limitations at a political, rather than a personal level. Most practitioners recalled touching on the Community Care Act in college, though much criticism was levelled against how this was handled. Some felt the practical issues were skirted around, others that the topic was overdone, repetitive or at an inappropriate level. There was a feeling that handling it at a theoretical level left them unprepared to cope in practice. Teaching methods did appear (from interviews, since this was not detailed in the curriculum documentation) to be varied, including debate and discussions as well as (optional) project work. However, a couple of HVs obviously learned more about the issues from other sources (local, national and professional papers and journals).

Category: Community Care Act and political issues (2)	Case study site: P
Commentary	Educational implications
The different emphases placed by DNs and HVs on the changes effected by the NHS and Community Care Act suggest, perhaps, that as much may be learned from practice and "current awareness" as from theory and policy in this area; this may be particularly true when the policy scene is changing fast and changes are relatively new. The two HVs who discussed information gleaned from reading also suggested this to be the case. Much of the data in this category reinforce issues from previous ones - notably the presence of ethical dilemmas where constraints hinder care. Matters pertaining to the Community Care Act were obviously covered on the course, despite its lack of emphasis in the curriculum - possibly because it was integrated within several modules as relevant (though the outdated reading list for social policy is obviously not helpful). Caldock's (1993) findings, because they reflect so much of the research evidence found here, may be suggestive of the fact that the practitioners' discontent with policy issues and their coverage may have occurred irrespective of its teaching. Philp & Dunleavy (1994), as well as Caldock, noted negative attitudes to community care among their respondents, while anxiety about unmet needs was also evident. The educational picture may simply be here a reflection of the wider scene, given, on the one hand, evidence that access to the White Paper (DoH, 1989a) was difficult (Caldock, 1993) and, on the other, complaints of "guidance overload" (Philp & Dunleavy, 1994). It would seem that the government, like educationalists, can maybe never get it right for all people!	Findings from this section highlight the difficulties of teaching in areas of social policy which is constantly changing. Two principles, noted earlier, can, however, be reinforced - firstly the need to prepare practitioners for coping with ethical issues in practice; secondly, the need to link theory and policy to practice explicitly, perhaps through some of the mechanisms suggested above. Caldock (1993) suggests that the loss of the initial impetus in the implementation of community care has led to the current lack of motivation and enthusiasm and that the provision of training for practitioners may restore this. Perhaps educationalists may take some solace from these findings!

Summary.

This section has shown the findings from the individual case study sites. The next chapter will show how this data was used to perform the cross case analysis.

7. CROSS CASE ANALYSIS

This chapter outlines the processes which bridged the gap between the single case and cross case analysis, leading to eventual integration of data across the whole study. It will explain the development of the analytic framework and associated rationale in some detail, giving a summary of initial results to demonstrate how they merged into a single whole. The full results will be detailed in the chapters 8-11.

Yin (1994) stresses the importance of theory in case study design. The notion of 'analytic generalisation' (rather than statistical generalisation) requires that a previously developed theory is used as a template against which to compare the empirical results of the case study. While the descriptive framework derived from the focus group data was useful and appropriate for both data collection and a richly descriptive analysis, it offered no basis for explaining the findings. A conceptual model of service quality, which has various features of direct relevance to the current study, is provided by Parasuraman et al (1985). This model has three underlying premises which pointed to its potential as a template theory for the final analysis within, between and across cases.

First, it acknowledges that service quality is more difficult for the consumer to evaluate than goods quality, as fewer tangible cues exist. The model, therefore, accepts the importance of identifying cues and underlying indicators which may be hidden rather than overt. This is consistent with the data collection approach, which postulated that needs assessment practices could not be fully examined through observation alone, but that it would be necessary to interview practitioners about their perceptions and rationale for overt activities.

Second, it assumes that quality perceptions result from a comparison of consumer expectations with actual service performance. The model highlights potential 'gaps' between expectations and actualities at different points along the service delivery network. Again; the reason for combining observation of actual performance of needs assessment with interviews, was to elicit and record any gaps between the actual practice of needs assessment, and the perceptions practitioners had formed about it during their educational preparation.

Third, the model recognises that quality evaluations are not made solely on the outcome of a service; they also involve evaluations of the process of service delivery. The interactive impact of different levels of the organisation on the quality of a service is acknowledged and taken into account. This aspect offered an analytic approach which would demonstrate the relevance of the data to both needs assessment and quality of care, enabling the integration and explanation of how the multiple sources of data may contribute to the whole reality of the practice of needs assessment.

These three underlying assumptions lead on to the specification of various propositions about five potential 'gaps' in service, which are both iterative and cumulative. Conversely, any aspects which help to reduce the potential 'gap' can be viewed as positive and conducive to service quality. The sixth proposition offers a summarising overview. The 'gaps' envisaged by Parasuraman et al (1985) are summarised below.

Gap 1: the consumer expectation - management perception gap.
The gap between consumer expectations and management perceptions of those expectations will have an impact on the consumer's evaluation of quality.

Gap 2: management perception - service quality specification gap.
The gap between management perceptions of consumer expectations and the firm's service quality specifications will affect service quality from the consumer's viewpoint.

Gap 3: Service quality specifications - service delivery gap
The gap between service quality specifications and actual service delivery will affect service quality from the consumer's viewpoint

Gap 4: Service delivery - external communications gap
The gap between actual service delivery and external communications about the service will affect service quality from a consumer's standpoint.

Gap 5: Expected service - perceived service gap
The quality that a consumer perceives in a service is a function of the magnitude and direction of the gap between expected service and perceived service.

Proposition 6: *Gap 5 = f(gap1, gap 2, gap 3, gap 4)*

However, there were two important aspects of this study which did not fit neatly with the model. In the first instance, there were two separate but closely linked 'services', each of which had different consumers. Students are consumers of education, but the data were being used to examine how, once they qualified, they were able to assess the needs of their clients - the consumers of clinical practice. Thus, the model was initially adapted as shown in Figure 7.1. It was felt that using parallel propositions about each of the two would illuminate the links between the kind and quality of education received by the students, and the quality of care they were able, once qualified, to deliver to health service consumers.

The need for further changes emerged during the analytic process which, as illustrated in Figure 5.1, requires a number of steps to develop the theory and the explanation-building potential of multiple case study design (Yin 1994). To begin with, the initial theoretical statement or propositions were compared to the findings of the first case. In the light of this, the propositions were revised, then compared to findings of the case again. Yin suggests that this process should be repeated with the other details of the case, with further revisions being made as many times as needed. The revised statements were subsequently compared with second, third and fourth cases, with repeated and further revisions being made. This iterative process led to further and more extensive adaptations to the original model.

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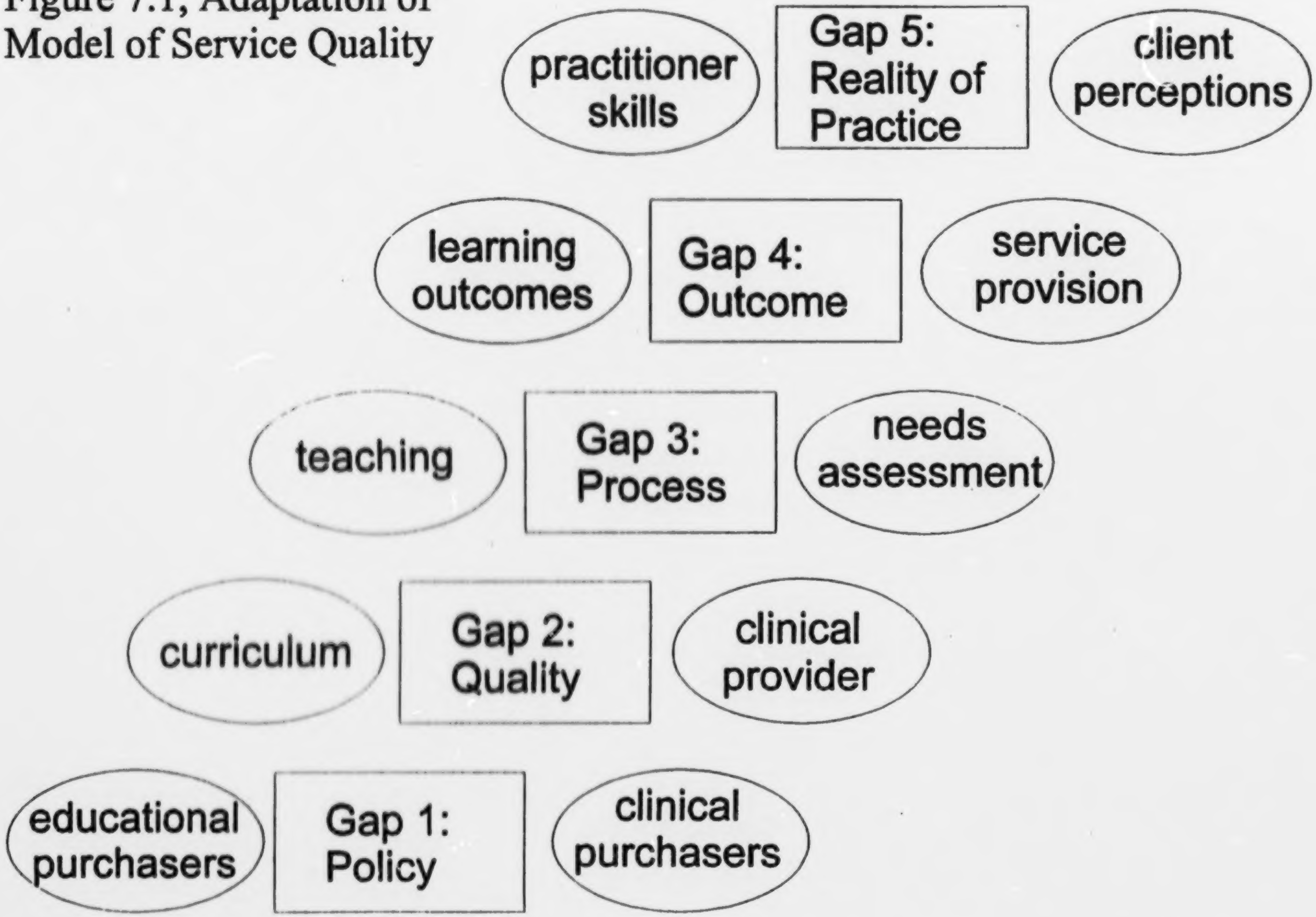

Figure 7.1, Adaptation of Model of Service Quality

practitioner skills
Gap 5: Reality of Practice
client perceptions
learning outcomes
Gap 4: Outcome
service provision
teaching
Gap 3: Process
needs assessment
curriculum
Gap 2: Quality
clinical provider
educational purchasers
Gap 1: Policy
clinical purchasers

As originally proposed, the model assumes a direct link between consumer and service provider. This is not really the case in either health service provision or education for professional qualifications. In both instances, there is a policy-driven mediator between them. The NHS and Community Care Act 1990 makes certain assumptions about the expectations held by consumers of clinical practice. In turn, these are translated into 'policy expectations' which are driven by purchasers acting as 'proxy' consumers, and service managers interpreting these expectations in practice. There is the potential for a 'gap' between the expectations based in policy, and that which is actually held by consumers. Students entering a course of preparation for a statutory qualification, likewise, may have expectations based on their perceptions of the community nursing role for which they are training. However, they are subject to external, employer-driven expectations about the skills they need to operate in their new role. In turn, these expectations relate to the policies established under the NHS and Community Care Act.

Thus, the relationship between the different elements appeared cyclical rather than linear. Further, a more explicit demonstration was required of the links between education and service outcomes. The underlying explanatory framework remained helpful, and the model as a whole philosophically in harmony with the study, but it became clear that the 'gaps' proposed by Parasuraman et al (1985) would need to be largely re-written to be useful to the aims of this study.

Through this analytic process, two significant changes to the original conceptual model were made. First, the number of 'gaps' was reduced to four because of the absence of direct data about how service specifications are established, contracts set and policy thus actualised into practice. These processes could only be examined through the eyes of the practitioners and, in any case, they lay outside the main scope of the study. Second, the iterative and cumulative links between the two services, as well as between the 'gaps' became clearer. Figure 7.2 shows the double-loop spiral which appears to operate, demonstrating how educational needs stem from service requirements for needs assessment; the quality of service provision, in turn, appears related to educational provision for practitioners who provide the service in practice.

For clarity, the gaps are explained individually below, with associated hypothesis, comments about the relevance for data analysis and a summary of the key points highlighted in the cross case analysis. The application of this framework to the aims of the study will be explained before detailing the overall findings in the next chapter.

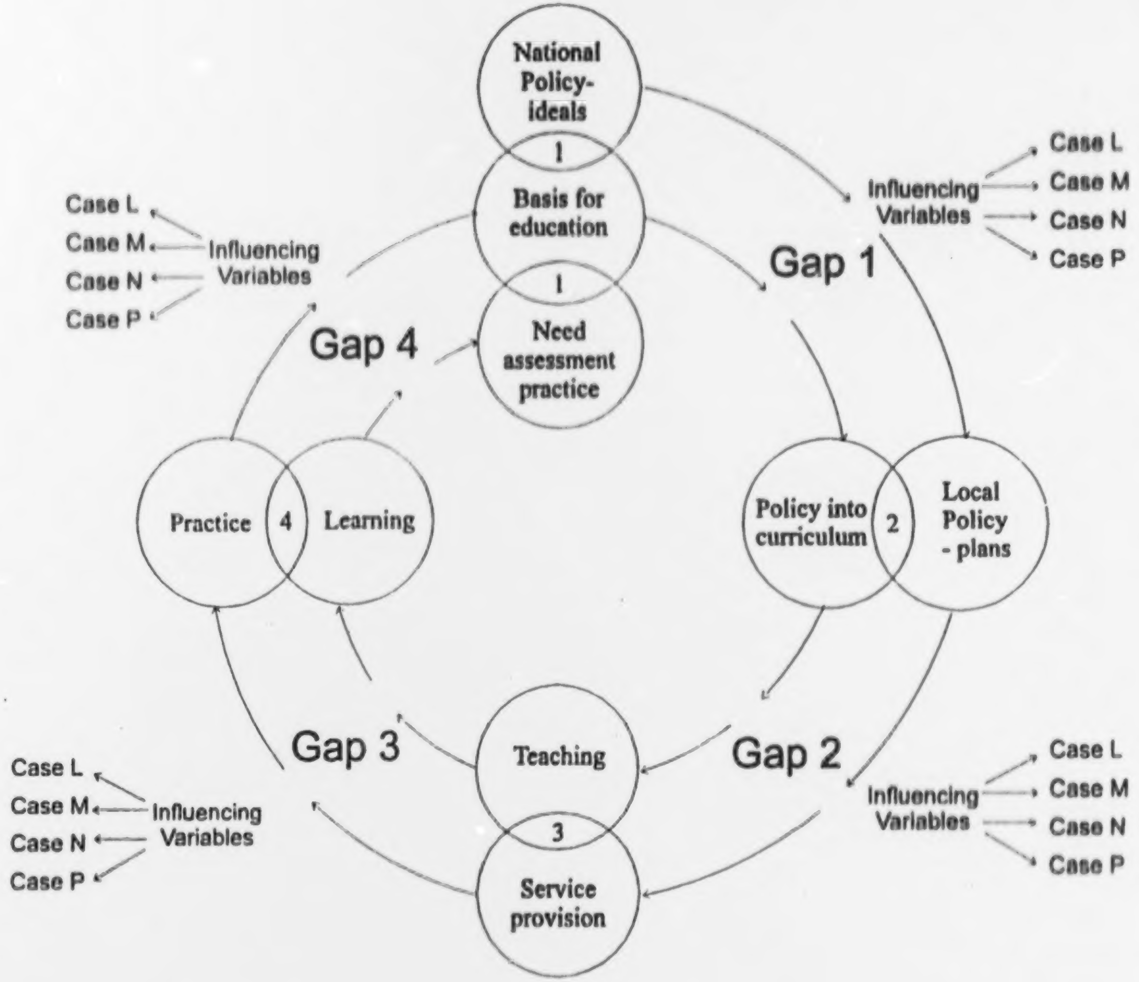
National Policy-ideals
1
Basis for education
1
Need assessment practice
Influencing Variables
Case L
Case M
Case N
Case P
Gap 1
Policy into curriculum
2
Local Policy - plans
Gap 2
Influencing Variables
Case L
Case M
Case N
Case P
Teaching
3
Service provision
Gap 3
Influencing Variables
Case L
Case M
Case N
Case P
Practice
4
Learning
Gap 4
Influencing Variables
Case L
Case M
Case N
Case P

Figure 7.2 Analytic framework

Gap 1: IDEALS INTO POLICY GAP

1A: Expectation For Client - Policy Ideals Gap

The gap between consumer expectations and policy makers' perceptions of those expectations will have an impact on the consumer's evaluation of quality.

In this study, the major policy referred to is the NHS and Community Act 1990, although it is acknowledged that this does not sit in isolation of other associated legislation about health and welfare. However, there are three key issues from this Act which are of importance to the analysis. First, there is a requirement for services to be responsive to the identified health needs of the population. Second, is the centrality accorded in the legislation to taking account of consumer views; working collaboratively with consumers and across agencies. Third, the rights of consumers to receive services was linked with a clear distinction between health and social needs, and the respective responsibilities of each of those services.

Observation data are the main source of consumer expectation in this study and opinions cannot be safely inferred from that. However, the policy itself was based on assumptions about the expectations of consumers, which is why this is expressed as an 'expectation *for* clients'. Furthermore, practitioners' interpretations of those expectations form part of the interview data, and the extent to which the educational process has inculcated values (explicit within the NHS and Community Care Act) of a needs led, collaborative service is relevant.

1B: Student Expectation - Education About Policy *Gap*

The gap between student expectations of what they should learn about policy, and educationalists' perceptions of what they should learn, will have an impact on the student's evaluation of the quality of education.

The relevance of nursing education for the implementation of the Act arises from the need to legitimise needs assessment in a way that can be formally recognised. Service provision relates to assessment of need carried out by a competent practitioner (rather than being delivered on demand, or in response to client assessment alone).

This creates a requirement for identifying practitioners who (through education and accreditation) are formally recognised as competent to undertake this function, and who have inculcated the ideas enshrined within the legislation. Students aspiring to achieve this recognition (with associated career prospects) need to learn about the legislative framework in which they are expected to work, and how to implement it. It is assumed that their perceptions of the quality of the education they receive will be linked to their ability to practice in their chosen career field.

Gap 1 *assumed client expectation - policy*	Gap 1 *student expectation - policy*
Case L • Practitioners identify with clients in assessments • Use of "empowerment" model evident • Social service led assessment not always in patients' interests • Ambivalence toward separation of health/social need • Lack of resources a constraint to client representation • Profiles a potential for representing clients but underused • Conflicts of interest within families made representation of need difficult	**Case L** • Generally policy sits uneasily with students' professional needs • Incongruence between simplistic policy view and professional view of needs as complex • Policy view of discrete assessment vs. need to link to provision • Need to know how nursing assessments fit in with official assessments & how to deal with differences in client/ professional perceptions • Multidisciplinary working difficult to operationalise
Case M • services intended to be needs led - but insufficient resources • services intended to be collaborative (including consumers) - but lack of communication between levels of hierarchy in organisation • clearly specified rights to, and responsibilities of health and social services - but conceptually difficult to operationalise	**Case M** • ideal of needs led services valued by practitioners, but their assessments (profiles) may not be valued or used by managers • ideal of collaboration hindered by lack of feedback at an organisational level • organisational division between health and social need not sustainable in practice
Case N • the idea of need portrayed in the NHS & Community Care Act appeared too limited; a more extensive, holistic view was held • interagency 'working together' was supported as an idea, but did not appear to happen much in practice • grappling with resource constraints pervaded the data; there was a feeling that only needs which could be met within existing resources should be highlighted on needs assessments	**Case N** • health and social needs were viewed as intertwined, and both were considered to be a nursing issue. • 'joint working' had been taught in College, and appeared relevant to many working situations. However, communication difficulties were common in practice. • coping with clients' disappointment and anger at being refused services for assessed needs was sometimes difficult.
Case P • Client views represented in profiles which influence provision • Representation limited by resources (fixed by policy) • Representation limited by competing demands (result of policy • Clients see a gap at the political level • Practitioners represent clients through political pressure (on policy) • But practitioners don't share these strategies with clients	**Case P** • Consumer perspective (policy) recognised but professional judgement may conflict • Discrete nature of needs assessment (policy) but ongoing assessment needed to promote client interest • Separation of health and social needs (policy) but nursing emphasis on holism • Interagency assessment (policy) but problematical in practice (Students need/expect learning to promote nursing ideals & reality

Gap 2: POLICY INTO LOCAL PLANS GAP

2A: Policy Ideals - Service Specifications *Gap*

The gap between policy maker's perceptions of consumer expectations and the service specifications will affect service quality from the consumer's viewpoint.

The policy intention for needs-led services, and the way this is interpreted in specifications for service contracts, may be confounded by different connotations attached to the notion of 'need'. Expectations, priorities, working patterns, assumed responsibilities between agencies and disciplines, too, may vary according the different philosophies; this seems especially likely if there is a lack of dialogue when setting up strategies and local policies. Locally established agreements about joint working and collaboration between health and social services (e.g., 'community care plans') are also relevant in this section, as a local interpretation of national policy.

The data did not give direct access to the community care plans or contract monitoring mechanisms used to ensure consistency and quality in a service. While recognising the strategic importance of such official plans, it was considered that practitioners' perceptions and awareness of their implementation would give a more realistic impression of their actual impact. Other indirect indicators included practitioners' contribution to strategy development and the contract setting process, their understanding of the purchasing agreements, and the way these were interpreted in practice.

2B: Relevant Policy - Interpreted in Curriculum Plans *Gap*

The gap between educationalist's perceptions (based on an understanding of service requirements) of what students should expect to learn, and specified curriculum plans will affect educational quality from the student's viewpoint.

Formal curriculum documents are acknowledged as a central part of the educational quality assurance cycle, although they rarely tell the 'whole story' of either the teaching or the learning processes. As a starting point, all qualified nurses are expected to be able to assess the nursing needs of an individual patient. Educationalists planning post-registration qualifying courses for community nurses need to build on that basic knowledge to develop specialist skills appropriate to the community setting. In addition, the requirements of legislation need accounting for.

The NHS and Community Care Act 1990 assumes an assessment of needs in order to plan and deliver services, both for individuals and to inform purchasing plans. Other legislation (e.g., Children Act 1989, Education Act 1993) also requires a full assessment of need. All these cases stress inter-agency collaboration and clearly specified responsibilities. It is assumed that educationalists will plan the curriculum according to their understanding of service requirements arising from this legislation.

Gap 2 *policy - specification*	Gap 2 *policy - curriculum planning*
Case L • Outcomes of needs assessment seen at individual rather than contractual level • Community profiles feed into contracting, though no feedback to practitioners • "Intuitive" profiles" difficult to feed into objective spec. data • Little practitioner influence in interagency agreements • Practitioners "caught" between clients and management	**Case L** • Curriculum documentation insufficiently detailed to comment on policy content • Need mentioned in broad terms only • Needs assessment within nursing models (DN) & policy context (HV) • Curriculum promoted interagency working and multidisciplinary learning
Case M • emphasis in contracts of quantification and prior specification of needs contradicted the variability and sensitivity required • impact of contract specification on practitioners: some aims and targets seemed unrelated to client needs • collaborative opportunities arose within and between agencies, despite the scarcity of formally convened joint assessments	**Case M** • policy emphasis on separateness of assessment as a single event conflicts with 'holistic ideal' beliefs held by practitioners • the diversity of assessment situations observed and discussed were not evident in curriculum document • the breadth of learning/skills required linked needs assessment to the whole curriculum
Case N • formulation of local strategies offers an opportunity to take account of culturally relevant views of need, although different perceptions may be held by professionals and clients. • assessment of needs at a level wider than the individual emphasised statistical data and links with workload • formal allocation of responsibilities between services was associated with ill feeling about the power balance, especially in relation to referrals and care management.	**Case N** • difficulties in communicating between agencies was considered to be a management responsibility, and linked with a perceived lack of respect for community nurses' judgement. • a wide understanding of local service provision was highlighted as essential for informed needs assessment practice • assessment was viewed as a holistic, continuing concept, which underpinned the whole of practice, but could not be separated from it.
Case P • Little involvement by practitioners in contracts • Policy emphasises individual assessment but there is no means for aggregating these into specifications • Profiling a means to this but practitioners not keen	**Case P** • Needs assessment taught within professional, not policy framework in curriculum document • Client centred philosophy (policy) not evident in curriculum • Interagency collaboration (policy) emphasised but limited to PHCT • Shared learning (policy) limited as evidence in curriculum • NHS & Community Care Act marginal in curriculum

Gap 3: PLANS INTO PRACTICE AND TEACHING GAP

3A Service Specifications - Service Provision *Gap*

The gap between service specifications and actual service delivery will affect service quality from the consumer's viewpoint .

The 'ideal' in terms of how the service claims or intends to promote and deliver assessment practices, may differ from how it actually happens ('actualised policy'). This 'gap' relates first to the formal procedures of establishing quality standards, mission statements and formally acknowledged parameters for the particular service. The interviews revealed the extent to which these were meaningful or helpful for the practitioners, and how their assessment matched their own 'ideal' standards. The observation instrument was designed to identify the extent to which client-led assessment actually happened in practice, and the use of documentation and records in practice.

Second, formal policies and strategies for interagency and interdisciplinary working are considered essential to the working of the NHS and Community Care Act. The issue of referrals to other services constitutes an important variation on the themes of liaison, collaboration and joint working.

3B: Curriculum Intention - Learning *Gap*

The gap between specified curriculum plans and actual teaching will affect educational quality from the student's viewpoint.

This study focused on courses which had been formally validated prior to full implementation of the NHS and Community Act 1990 (the 'community care' part of the Act was not operationalised until 1993). Nevertheless, it sought to discover the process of how students learned about that Act, as well as about needs and needs assessment.

All the practitioners involved in the study had achieved 'competence' in their chosen field, as evidenced by their qualification. Data collection occurred some months later, to discover how well their learning had prepared them for practice. Inevitably, this means that practitioners will each have encountered some differing influences and expectations of their practice from colleagues, clients and managers. However, it also allowed an assessment based on the reality of needs assessment practice, of how effective they perceived their preparation to have been.

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Gap 3 *specification - provision*	Gap 3 *curriculum - learning*
Case L • Structured agenda for assessments but not clear who formulated these and not rigidly adhered to • Dissonance between specifications (service definition of need) and client need • Mission statements little influence on practice (management written) but used as bargaining tool	**Case L** • Need for knowledge base identified for practice (?reflected in curriculum) • Assessment learned apart from policy context • Inadequate grasp of NHS & Community Care Act due to insufficient teaching content, though some methods helpful • CPT central to effective learning both pre- and post-qualification
Case M • making and receiving referrals; linked with liaison and responsibility for client • 'working together' as everyday work; importance of interpersonal communication and delegation • 'needs assessment' as integral to all work, not a separate event • potential for different priorities within families/communities, as well as between client, practitioner and service.	**Case M** • the importance of experience in practice and role of practice teachers • use of models/assessment tools; learning about systematic and specific assessments • developing professional judgement and professional self-confidence
Case N • 'working together' occurred mainly in relation to formal situations, although there difficulties in practice. • practitioners' assessments of need on their own caseload were often 'intuitive' and not cross-checked with formal data. • client held records and self-assessment were cited as a helpful approach to improving client centredness, although they were not observed to be in common use.	**Case N** • to undertake a meaningful needs assessment meant understanding the complexities of family situations and dynamics, and taking account of carers. • professional judgement is needed to balance the different perceptions of need and want. • some assessments are purposeful and structured, but in other situations they serve only as 'entry behaviour' to begin the process of service delivery.
Case P • Specifications peripheral to main nursing needs assessment • Intuitive profiles used as alternative or supplement to official profiles in practice • Practitioners largely unaware of mission statements - little influence on practice	**Case P** • Needs assessment taught within nursing process • Skills taught within discrete subjects e.g. psychology • Interagency education primitive • All students completed profile though guidance inadequate • Learning often related to extra curricular topics outside college • NHS & Community Care Act "overtaught"

Gap 4 PROVISION - PREPARATION - PRACTICE GAP
Gap 4= f(gap1, gap 2, gap 3)

4A: Service Provision - Educational Preparation *Gap*

(Gap 1): The gap between the consumer's actual expectations and policy ideals about needs assessment, plus
(Gap 2): the gap between service specifications and their translation into actual service provision ('actualised policy')
(Gap 3): used as a basis for students educational preparation,
(Gap 4): will affect practitioners ability to assess consumers needs.

The links between service and education become more evident once the skills learned in college become the basis for actual practice. This study did not access clients views of their expectations of the needs assessment services they expect to receive. However, the extent to which practitioners are able to deliver the service which clients expect to receive also relates to the skills of practitioners in assessing needs, to their ability to access appropriate services on behalf of their clients and to influence the availability of service provision.

4B: Learning as a Preparation for Practice *Gap*

(Gap 1): The gap between student expectations of what they should learn , and educationalists' perceptions of what students should expect to learn, plus
(Gap 2): educationalists' perceptions of what students should learn based on their understanding of service requirements, and the way this is specified in the curriculum, plus
(Gap 3): the gap between the curriculum plans and the actual teaching, will (Gap 4): affect practitioners ability to assess needs effectively as qualified community nurses.

Once their programme of learning has formally finished, the newly qualified practitioners enter a period during which they need to consolidate their skills. They may soon discover that their learning is far from complete, although (if employed as qualified community nurses) they will be expected to take full responsibility for practising in their new role. The idea of 'self-directed practice' presumes an ability to recognise and act upon one's own learning needs. For the purposes of this study, the extent to which students are prepared for this transition is pertinent.

Gap 4
provision - educational preparation and learning - practice

Case L

- Need in practice - subjective, complex, individual, changeable, context-bound, with potential for conflict
- Needs assessment in practice - ongoing, professional, linked to provision, but within policy constraints, separating health /social
- Education & policy for needs assessment - simplistic, objective, stable
- Education for policy - inadequate, leaving learners unprepared, especially when newly qualified. Benefits of learning not always immediately obvious. Learning needs to proceed beyond qualification.

Case M

- coping with the diversity of assessment situations was challenging
- need to take account of the unpredictability of post-qualification support for continued development
- need to consider the variability of each individual learning trajectory
- need to achieve self-directed learning; responsibility for own professional development; importance of supervised practice

Case N

- The role of the community practice teachers was seen as central to facilitating suitable learning in the practice field
- Practitioners only fully realised the relevance of the extensive and variable theoretical knowledge required after qualifying
- The amount of personal development and professional development required created a high degree of stress and sense of vulnerability during the course, and when the practitioners were first qualified.

Case P

- Practice:
    - need complex
    - nursing/policy conceptualisation of needs assessment
    - resource constraints/lack of guidance
    - intuitive
    - innovatory
- Preparation - policy and theory but little attention to ethical dilemmas and decision making for above

APPLYING THE THEORETICAL FRAMEWORK

The double-loop spiral (Figure 7.2) illustrates the cumulative and iterative nature of the cross case analysis. The underpinning assumption is that the quality of a service (in this case both practice and education) can be assessed through the identification of 'gaps' within the service chain from customer expectation to service delivery. Thus, although negative examples from the data need to be highlighted in order to rectify deficiencies, positive examples also need to be described in order to identify good practice comprehensively.

The outer ring represents the gaps in the practice dimension, linking client expectations to service provision as a basis for student preparation. The inner ring illustrates the parallel educational dimension, highlighting the gaps between student need for preparation and its evidence in practice. The move is thus from practice to education to practice, via critical aspects of needs assessment practice and education identified within the circles.

Each gap can be seen to be cumulative in that any existing gap between two circles is augmented by any previous gaps in the chain. As the spiral moves from the first (practice) to second (education) cycle the accumulated practice gaps compress to make the reality of practice a basis for the student's need or expectation for educational preparation. This assumes that any educational programme is preparing for the reality, as well as the theory, of practice. The cumulative outcome of the education cycle is evidenced in service provision. The process of analysis is also iterative, not only in the way the gaps are identified within both the practice and education arenas (the overlapping nature of which is depicted by overlapping circles) but also in the way the variables which constitute the gaps are identified for each case.

Application to aims of the study:

Yin (1994) warns that the cumulative and iterative process of explanation-building may lead to a slow drift away from the original topic of interest; he advises constant reference to the original purpose of the inquiry to help safeguard against this. Before outlining the major results of the cross-case analysis, therefore, the nature of those findings will be linked to the research aims.

The pattern-matching procedure resulted in a description of needs assessment at the four different levels, from the most strategic level of national policy, through interpretation of this into local strategies, thence into service specifications and finally the application of needs assessment in practice. This fulfils the first aim of the study,

1. To describe what clients/patients, service managers, purchasers, teachers and practitioners mean by the term 'needs assessment' in the context of community nursing.

Examination of the parallel processes in education fulfil the second aim, which is

2. To describe how current educational provision relates to needs assessment for district nurses and health visitors.

For both of these aims, the descriptors were derived from the pattern-matching procedures carried out within and between cases. They remain at a largely conceptual level, although links to relevant literature are made where this adds strength to the analysis. The descriptions of needs assessment may be manifest in practice in entirely different ways in two cases, but a pattern is established if a shared logic exists between them; this is theoretical replication (Yin 1994).

The search for rival explanations and both literal and theoretical replication are important aspects of the analytic procedure. The explanation-building processes built into the examination of which 'gaps' could or did arise at each of the stages relates to the third and fourth aims, which are:

3. To assess how current educational provision relates to needs assessment in the light of changes contained in the NHS and Community Care Act 1990, with particular reference to inter-agency collaboration.

4. To identify models of good practice in needs assessment, bearing in mind quality assurance requirements and the differing viewpoints of service users, purchasers, practitioners and managers.

Widely applicable explanations are derived through a process of analytic (rather than statistical) generalisation (Yin 1994). Thus, these processes are considered across the four cases through a replication logic to derive factors which need to be taken into consideration when planning educational preparation for needs assessment. The format of this final description and explanation is a result of these repeated and cumulative analyses so a direct link back to specific data points is not always either linear or immediately obvious. However, it offers a fresh way of considering the educational needs of community nurses and provides a sound basis for fifth aim of the study, which is:

5. To develop recommendations for future educational provision in community nursing programmes, relating to needs assessment.

This last aim is considered in the final section of the report (chapters 12 and 13), along with responses from an expert group to initial draft recommendations. First, the major results derived from the analysis will be detailed.

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8. IDEALS OF NEEDS ASSESSMENT

The ideals of needs assessment were manifest in the data under three key areas. These will be described before explaining the facilitators and constraints to their implementation in practice and in education, which sets the scene for the first potential 'gap' to arise. First, implications of the ideals relating to policy were demonstrated; on the whole, this concerned the NHS and Community Care Act 1990, although issues relating to the Children Act 1989 were also relevant, especially to health visitors. Second, the nursing ideals of holism in needs assessment emerged strongly across all cases. Such ideals may be translated into varying degrees of 'worth' or acknowledged value ascribed by assessors, by those being assessed, provider unit managers and purchasers, and by policy makers in general .

Policy

The ideals of needs assessment in policy focus on specifying the position of both the assessors of need (the practitioners), and those being assessed (the consumers); and on the influence in both cases of their ascribed roles, responsibilities, rights and available resources, as shown in Figure 8.1.

Figure 8.1

Ideals of Needs Assessment in Policy

Focus on specifying:

- **position of consumer**: as sole, joint, primary (lead) or secondary assessor, or recipient of services assessed by others
- **position of practitioner**: as sole, joint, primary (lead) or secondary assessor, or responsible for delegated duties assessed by others
- **roles** as assessors and referral agents: may be formally acknowledged - fully, partially or not at all; likewise respect for consumers and practitioners in this regard
- **responsibilities:** may be conferred (eg by national policy, such as health/social divide, or by local service planning strategies), may be claimed by service, practitioner or consumer (including family/carers) or may be accepted with varying degrees of willingness
- **rights:** may be explicit and overt, or obscured (intentionally or unintentionally, knowingly or not)
- **resource availability:** may influence needs assessment or not; influence may be explicit and overt, or obscured (intentionally or unintentionally); such influence may be permitted in policy or not.

These variations may apply in statute as national policy, or may inform the local interpretations of that policy. While local strategies may stand apart from, or in addition to, the nationally mandated approach to needs assessment, this study is focusing particularly in the impact of the NHS and Community Care Act 1990. However, the NHS and Community Care Act, 1990 is not a comprehensive statement of the regulations and policies affecting community care, it is merely the most recent addition to a wealth of law stretching back as far as he early part of this century.

Indeed, some other pieces of legislation are at least as relevant to community nurses; the health visitors in the study were generally more aware of the Children Act than the NHS and Community Care Act, and provisions of the Disabled Persons Act (1986) may be viewed as directly relevant to district nursing. Moreover, Fishwick (1992) argues that the legislative framework which governs community care is extremely complex because there is no single piece of legislation which attempts to gather up all previous laws. Means and Smith (1994) point out that this makes it very difficult for local and health authorities (as well as clients and their carers) to be certain of all their duties, rights and responsibilities. Thus, whilst it is possible to make inferences about the ideals of recent policy relating to need, it is also possible to find contradictions between and within policy statements (Caldock, 1995; Young, *in press*). While some commonalities can be discerned, the manner in which need is defined varies quite markedly between the different Acts (Figure 8.2).

Moreover, the concept of assessed needs in individuals is considered entirely separately from the requirement on health authorities (or their successor health commissions) and GP fundholders to assess the health needs within the populations they serve, and to purchase suitable services to meet those needs (DoH 1989b). At this level, the idea of 'need' seems to be regarded as a fairly static and simplistic. Likewise, the distinction between purchasers and providers could be said to presuppose a quite naive view of the two sets of responsibilities as mutually exclusive. Monitoring of implementation (DoH 1994b) has shown that, while at a macroscopic level it may be possible to separate these two functions, at the level of individual care (where community nurses have the most input) it is not so clear cut.

Furthermore, the idea of need as a concept which is separable into two distinct aspects known as 'health needs' and 'social needs' is implicit in the specification and division of responsibility between the two different services (DoH 1989a, 1989b). In both cases, it is presumed that services will be established to meet assessed needs; allocation of resources is addressed in as much as what constitutes a 'proper' call on the budgets of the respective services is laid out in the associated working papers. These are, of course, subject to revision, and issued from time to time as guidance from the NHS Executive or Social Services Inspectorate.

Notwithstanding this division between the services and specified responsibilities, there is a strong emphasis on collaborative working within the Act. Perhaps to counterbalance the normative emphasis on identification of need, the position of consumers, likewise, is stressed as being of central importance with special attention being afforded to the involvement and representation of the views of service users at all levels of needs assessment (SSI 1991). The key ideals of the NHS and Community Care Act 1990 were highlighted in this study by the understanding expressed by one health visitor:

> '. . . having done joint needs assessments with social services working in the Community Care Act - the Act highlighting who was doing the assessments and when we should be doing them and how we should be doing them. . . . . things that strike me about the Community Care Act is the working together, issues of different professionals with social services and with health professionals and I suppose when you have children with special needs or child protection issues is when you work closely with other professionals particularly in the social sphere rather than just health' (HV 5 Case M)

Figure 8.2
Definitions of 'Need'

<table>
<tr><th>Children Act 1989</th><th>NHS and Community Care Act 1990</th><th>Disabled Persons Act 1970
Disabled Persons Act 1986</th></tr>
<tr><td>A child is deemed to be 'in need' if he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority; or if his health or development is likely to be significantly impaired or further impaired, without the provision for him of such services; or if he is disabled.
(Section 17: 10)</td><td>No definition of need in Act, but specification in working papers:
Need is seen as the requirement for 'individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life as defined by the particular care agency or authority'
SSI 1991: 12</td><td>No definition of need in Act, but specification in working papers</td></tr>
<tr><td colspan="3">Implicit Assumptions about 'Need'</td></tr>
<tr><td>Needs are defined in terms of existing local authority provision
Client centred assessment of need is achievable when need is seen as ability to benefit from services
Need is seen as something which is developed and addressed over time
Needs are incremental
Family needs are closely intertwined with a child's needs, but are of secondary importance if the child's needs are created, maintained or exacerbated by the family</td><td>Wants can be separated from needs
Assessment can be separated from care
Health and social care can be separated meaningfully
Needs can be defined objectively
Need can be met with existing resources
Need can be met by flexible service provision
Client-centred needs can be prioritised and services rationalised meaningfully at a purchaser/provider level</td><td>Need is defined only within strict boundaries
Need is objective
Need assessment is not influenced by resource levels
Need is defined by professional or expert rather than disabled person
Clients who initiate assessment process have needs which can be accommodated within the existing system</td></tr>
</table>

Themes from the Act which appeared influential were linked to the ideals of needs-led services which are orientated to consumers, and which work jointly and collaboratively. In their 'pure form', these concepts appeared very little in the data, which will be considered further below. Also, while these policy ideals are not necessarily opposed to the more traditional ones which appear within a nursing framework, they differ in emphasis and in certain key respects.

Nursing

In a nursing approach, a holistic philosophy and the ideal of 'wholeness' may be seen to underpin the idea of needs assessment at different levels and depths; it may also help integrate different aspects of personhood (Figure 8.3).

Figure 8.3

Nursing Ideals of Needs Assessment

- **levels:** may focus on individual; family; whole area, community, group or caseload
- **depths:** superficial or 'easily seen' needs; deep or deep-seated needs; hidden, submerged or unacknowledged needs
- **aspects:**
  - ***physical*** eg, health; illness; disability; dependence
  - ***psychological*** eg, emotional; affective; cognitive,
  - ***social*** eg, practical ('coping'); financial and housing; family and social network; community
  - ***spiritual*** eg, religion; culture; belief systems

The extent to which such ideals were translated into practice varied (which will considered further below) but the 'holistic emphasis' was ubiquitous in the data, featuring in interviews in all the cases. Even though one level or aspect might be uppermost at the time, this was not the same as the 'separate' emphasis in the policy; for example:

> ' . . . assessment of needs of the patient who in turn is a part of the community.'
>
> (DN5 Case N)

> 'needs assessment is looking at the family's health, um, that's holistic; maybe using a model, but basically you can get the four basic codes that most models encompass, physical and social, psychological, environmental health.'
>
> (HV2 Case M)

> 'I think looking at the client's need in terms of their physical, mental, psychological, social, cultural, whole - holistic needs . . . and looking at the family as well
>
> (DN1, Case L)

Awareness of the complex and variable nature of need emerged from some of the descriptions of the different depths of need; for example, needs may be immediately obvious, or hidden and potentially overlooked by both client and practitioner:

> 'if you're going to someone who's perhaps had minor surgery and maybe had a few stitches - it's straightforward . . . '
>
> (DN2 Case M)

> 'There may be a need that may not be recognised by the parent - there is every likelihood that they could have slipped through several nets; some things may not have been picked up . . . '
>
> (HV2 Case P)

The relevance and importance of acknowledging that the client's perceptions of need may not coincide with those of the professional was also widely acknowledged in the interviews across all the cases. Again, the extent to which this was translated into the observed practice will be considered below. This leads on to the third 'ideal' of needs assessment, which concerns the ascribed value or worth.

Ascribed worth

Ideals may be translated into varying degrees of ascribed worth or acknowledged value (Figure 8.4). Different degrees of 'worth' will be ascribed by the various actors in needs assessment, and will vary according to the different conditions pertaining at the time, thus:

Figure 8.4

Ascribed Worth in Needs Assessment

Worth or 'value' will be attached by:	Worth or 'value' attached will vary according to:
• assessors; • those being assessed; • provider unit managers; • commissioners and purchasers; • policy makers	• perceptions of 'health' and its link with need; • service structures (eg, health and social) • contract specifications • type of needs assessment; (eg, approach and assessor)

These differing values combine with the alternative ideals expressed in policy or in the nursing perspectives to demonstrate how changeable and potentially disputed is the base line for examining 'needs assessment' in community nursing. The 'ascribed worth' is not necessarily static either; it may change according to circumstances. As an example, the power given to commissioning authorities under the NHS and Community Care Act 1990 suggests a higher worth is accorded to the needs assessed and prioritised by purchasers at a broad population level than to local and individual needs assessed and prioritised by community nurses. In practice, the needs may be identical; the varied extent of power is associated with different 'worth' attached to community nurses or purchasers as assessors.

Different views may arise from the perceived role of the assessor, of the level of assessed need and opinions about which needs should be prioritised. In both cases, the perceptions of need held by service users may be entirely different, although both practitioners and purchasers tend to claim a monopoly on best representing the consumer view. Notwithstanding the shifting and value-laden nature of this starting point, focusing the analysis on the different ideals and the facilitators and constraints which arise as they are converted into policy, demonstrates the potential for the first 'gap' to arise.

GAP ONE: IDEALS-INTO-POLICY

Needs-led services

The importance attached to 'need' as a fundamental concept which underpins both the nursing and policy ideals could represent a shared point of reference between the two different outlooks. However, a recurring issue related to the limited extent to which most of the practitioners were able to conceptualise need as an abstract concept, or to recognise the assumptions which underpin policy apart from the context in which they operate. On the whole, need was only expressed as an abstract or separate concept in response to a direct question - and not always then - or when explaining how it was taught in college.

It may be that need can only be fully conceptualised in relation to the context in which it exists, and certainly there is considerably more literature about needs assessment than about the issue of need alone. However, there is a literature about ways of considering need (eg Bradshaw 1972, Doyal and Gough 1991, Lightfoot 1995, Maslow 1943), and many of the practitioners were familiar with Bradshaw's taxonomy of needs (Bradshaw 1972). Even so, as shown in the single case analysis and summarised in Figure 8.5, need was not well represented as specific and separate issue in the curriculum documents.

Figure 8.5

Concept of Need

Curriculum document	Representation of need as a concept
Case L	Need was mentioned only in the broadest of terms; DN course described the holistic nature of need and HV course recognised needs as subjective
Case M	Taught 'health visiting needs '; needs of individuals and communities appeared in sociology (HVs). Health and social needs were not distinguished. Assess needs of individuals and families (DN)
Case N	Need as a concept only appeared within the context of 'nursing need' within the document.
Case P	The only explicit mention of need appeared in the sociology/social policy module in the context of 'needs, wants and duties'

Need as a topic was usually mentioned only in a broad sense within the curriculum, and documents certainly failed to reflect the diversity of practice which was observed. The subject was clearly envisaged by programme planners as sitting within a professional framework, often based on nursing models, particularly within the district nursing syllabus. It appeared more often within the health visiting curriculum as a part of the social policy content; however, this was policy in general rather than specifically related to the NHS and Community Care Act. Several of the courses had been validated prior to the implementation of this Act, so the topic was not well represented in the curriculum nor, according to many of the practitioners, was it particularly well taught. This will be considered further below.

Arguably, unless they are able to understand need as an underpinning, abstract concept, practitioners will run into repeated difficulties when contexts shift or distort the concept in a way that was not anticipated. In some aspects, the NHS and Community Care Act 1990 appears to be based on a comparatively static and simplistic view of the concept of 'need', for example, but this view contradicted the professional nursing perceptions represented in the data which generally emphasised the personal, changing, unexpected and continuing nature of need.

> 'There's always something that needs to be looked at again' (DN3 Case P)
>
> 'Need is about perception, need is how people see it . . .' (DN5 CaseN)

Practitioners across all cases expressed concern at this lack of congruence between a (professed) client centred policy, which appeared to take a simplistic view of needs assessment, and a 'nursing' philosophy, which represented the client through acknowledging the complexity of individual needs within a holistic context. The situation could also be made complex by virtue of the fact that the assumption that client and professional would necessarily share the definition of need did not automatically operate. The practitioners were, on the whole, highly cognisant of the dangers in assuming a shared view of need;

> 'Need is a very individualistic concept; we could be in danger of imposing what we perceive as somebody's need on people . . . ' (DN3 Case P)
>
> 'A nurse may think the person's needs are - whatever - may organise accordingly and it may not be what the patient wants at all.' (DN5 Case N)

These high ideals were not universally carried forward into the observed practice, and take no account of the issue of 'ascribed worth' which sometimes surfaced. One practitioner held a different view of the need to the client, who had considered housing was the major concern, for example; the health visitor suggested that she should aim:

> 'to make them realise that housing is not the main issue here, its a family problem, social problem, not from the housing . . ' (HV1 CaseL)

At a more general level, the different values attached to different views of need may be manifested as different priorities; it is not necessarily possible to determine which come first. Perhaps one of the most influential reasons for different priorities, for example, was in relation to the issue of resource availability. The official intention of community care policy is that services should be provided according to assessed needs, taking account of consumer views. This is stated explicitly in the first two components of community care as put forward by the government, which are 'services that respond flexibly and sensitively to the needs of individuals and their carers,' and 'services that allow a range of options for consumers' (DoH 1989a para 1.10).

Notwithstanding this fine ideal, in all four cases there was strong evidence that service provision was limited by resource constraints at least part of the time. Sometimes this meant that knowledge of resources available actually determined the assessment itself, which contradicts the stated intention of the policy.

> I: 'What do you do now, if you want to change the package of care?'
> DN: We can't, no, what I would have to do is use that time in the afternoon.'
> I: 'What do you mean by that?'

> DN: 'Mm, I, we can't, I haven't got, there's not enough staff to go in there everyday' (DN3 Case L)
>
> 'I mean where you go into a situation and take into account the person's domestic and social circumstances, I think it still tends to be very limited with time restraints and actual resources. And then of course if you are identifying certain needs, you've got to be able to provide that care . . '(DN2 Case M)
>
> 'The resource element, being policy driven, prevents me from perhaps giving the total needs led approach' (HV4 Case P)

Consumer oriented services

As indicated above, the practitioners subscribed strongly to a 'holistic ideal' to underpin assessments, as a means of taking consumer views into account. However, the distance between these individual assessments and the policies being laid at national or trust level appeared so great, that strategies often seemed to practitioners to be irrelevant to the needs of their clients.

> 'I think its very difficult sometimes because particularly higher up within the health service, people, thinking particularly about health of the nation targets, the people setting the targets perhaps haven't got a realistic experience of certain topics. Like, for example, immunisation rates in a certain area. In a case that I work on we have a caravan site with travelling families and we know those children will very rarely get immunised and yet the people higher up who are setting a target haven't allowed for people like, they think everybody is perhaps in the same situation . . . .'
> (HV4 Case M)

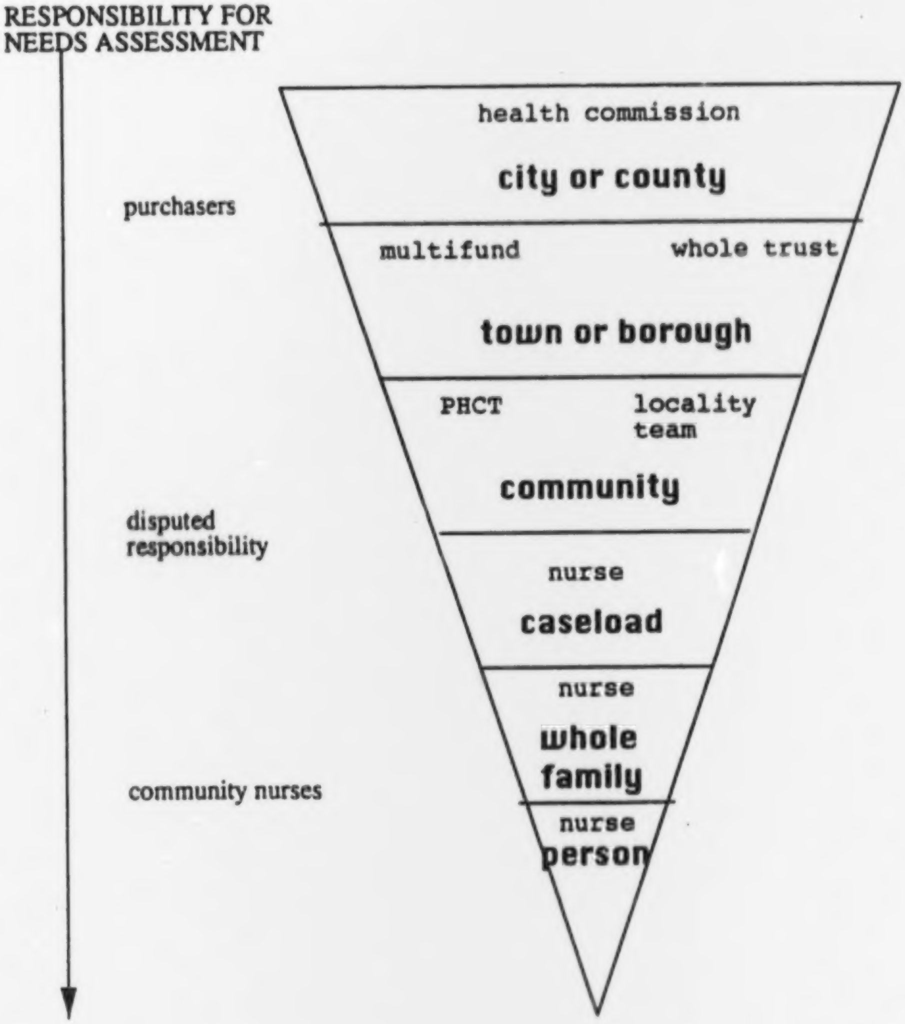
Coping with these discrepancies in the practice situation will be considered further under gap 3. A few practitioners did feel able to make representations which would influence the process of policy development at a local level, but others complained of a lack of feedback, or that their views were not sought or taken into account. Indeed, some appeared quite unaware of how local plans were developed, or their link to national policy. However, in all four cases practitioners felt consumer views could be represented through professional practice and community profiles of need.

> 'The DHA, the purchasers could well be interested to see what is going on at grass roots level, of small localities, because this must form part of the overall picture . . '
> (HV2 Case P)

These profiles did not always realize their potential in this regard, perhaps because their value as a means of representing consumer views are not formally acknowledged within the policy, which presumes that obtaining consumer views is a purchaser responsibility. The worth ascribed to needs and views collated in such profiles may relate to the area of disputed responsibility in the 'middle levels' of assessment (Figure 7.4).

Individual (one person) and (usually) family assessments are generally accepted as the domain of community nurses, and population wide assessments are clearly specified as the responsibility of purchasers. The point at which these meet - and views about the extent to which individual and family assessments can be meaningfully aggregated - remains a point of dispute, which will considered further below.

Figure 8.6: Responsibility for needs assessment


RESPONSIBILITY FOR NEEDS ASSESSMENT
purchasers
disputed responsibility
community nurses
health commission
city or county
multifund
whole trust
town or borough
PHCT
locality team
community
nurse
caseload
nurse
whole family
nurse
person

Certainly, a purely 'top-down' approach tends to send rather mixed messages to practitioners who would aspire to seek and take account of their clients needs and wishes. Indeed, Lloyd (1991) argues that a 'bottom up' approach which advocates the clients right to express their needs, be consulted about the services offered, to control the delivery of care and to protest when things are wrong is incompatible with the'top down' approach of management deciding who is needy, allocating resources and adopting a 'professional expert' stance towards the dependent recipient of services. The representation of client views through political pressure suggests an advocacy element within needs assessment which could potentially help to counter this. While this approach was not frequently seen in the data, it did appear:

> 'You do get political . . ' (DN1 Case P)

> 'I see myself as the patient's advocate in a way that if there is a plan that has to be put down and things aren't going to plan, it's being the client's advocate if they have tried and aren't getting anywhere . . ' (HV4 Case M)

Indeed, practitioners suggested that clients themselves would, perhaps, encourage this politicising movement especially if they perceive gaps between their views and policy.

> 'If you ask people to look at what their needs are that raises their expectations and it causes dissatisfaction when their needs aren't met - that causes me a problem. . . . they [clients] receive it on a very political level. Luckily I haven't usually experienced anger aimed personally at me' (HV3 Case P)

> 'There's an individuality about assessment and choice, but when it comes to the end people are still looking for a uniform service - they think it's unfair otherwise' (DN3 Case N)

Paradoxically, too, guidance for practitioners (SSI, 1991) seems to ignore the ideal of 'searching for needs' which has become a feature of good community nursing practice (CETHV 1977, Chalmers 1993). Though a proactive stance is advocated, this still assumes an initial enquiry or referral to a passive practitioner. This was firmly contradicted by the observation data, which showed that the majority of visits involved at least some element of a 'searching' for hidden, barely visible or potential needs (Table 8.1). Where this 'search' was not present, it was often because the nature of the visit was pre-determined and specific, such as a post-operative visit to remove sutures, for example, or to follow up a conversation in a recent clinic visit.

Table 8.1:

Attempt to discover hidden, barely visible or potential needs?

Case	Yes	Un-sure	No
L	24	1	14
M	18	2	7
N	22	0	5
P	8	3	20

Collaborative services

The policy ideal of collaborative and joint working across health and social services presupposes agreement on respective agency roles in assessing and meeting need. The assumption is that jointly prepared community care plans will specify the services to be provided, and that both health and social service workers will be clear about which aspects of assessment and care provision they are responsible for (SSI 1993).

However, the division between health and social need which is required for the specification of responsibilites conflicted directly with the holistic nursing philosophies which were often the basis for theoretical teaching on needs assessment. In all four cases, there was agreement that health and social needs were not separable within the client context; indeed one practitioner was amazed to be asked about the distinction, having never previously considered separating them.

> HV 'Well I think I think social's part of health - it depends sort of - how you describe health . . .'
> *Int 'We were interested in that because of the health and social divide under the NHS and Community Care Act, but . . .'*
> HV 'I've never really thought of it as being - I mean, I know the health services and social services are two different departments, but I think where we are as health visitors it's got to be in the middle . .'
> (HV3 Case M)

> 'looking back, thinking back to the course I did and nursing in general, looking at people in a holistic way, yes, so, we are talking about the physical environment, where people live, their emotional and mental health needs, their social needs, financial circumstances, so I would say its broadly a holistic assessment.'
> (HV3 CaseP)

> 'Who determines social health? When does a social problem become a health problem or when does a health problem become a social problem? The two are intertwined - you can't separate them.' (DN 4 Case N)

Thus, the concept only becomes separate in relation to deciding which service should be responsible for meeting the needs. This confusion resulted in a lack of clarity as to how the nursing assessment fitted in with other 'official' community care assessments; as one district nurse stated:

> 'Anything that's a need, I should be assessing.' (DN4 CaseP)

Notwithstanding the 'territorial views' that were expressed, the idea of joint working was generally well accepted as a good way of husbanding resources. Several areas of possible duplication or overlap were noted, but disagreements about responsibilities were often linked with resource difficulties or with different views about what constitutes need.

> 'I believe there is an overlap to a certain extent of the roles of people who work for Social Services, particular with the under 8's and health visitors. I think we do duplicate a lot of the work actually. I think we could actually work together a lot more. But I think you come to the problem of who pays for it, Health or Social Services. (HV3 Case P)

> 'Like joint meetings I'm having ...with Social Services...and what peoples' needs were and how we differ in what we think people' needs were'
> (DN3, Case L)

Most of the practitioners recalled learning about joint working as a major feature of the NHS and Community Care Act, but the reality did not necessarily live up the ideal. One district nurse stated flatly:

> 'There's us and there's them - we're not working together. The principles right - the reality's different.' (DN3 CaseN)

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To summarise, the ideals represented within the NHS and Community Care Act make some assumptions about the nature of need, about how consumer views might be represented in planning service provision and in operationalising joint working plans into practice. Some of these assumptions conflict directly with the nursing ideals about the nature of need, and how its assessment can be used to represent consumer views and to inform collaborative service provision . However, even where the ideals are entirely consistent - for example, in accepting the importance of collaborative working and in acknowledging the consumer view - conflicts seemed to arise, and a 'reality gap' could be seen to be opening. The way these ideals were operationalised into local policies will be considered next.

9. TYPES OF NEEDS ASSESSMENT

To translate the ideals of needs assessment into reality requires planning, organisation and a means of specifying 'how' this should be achieved. This requires consideration of the huge diversity of different situations and types of assessment which are potentially possible. Apart from the acknowledged purpose - a starting point for protocols and specifications - each assessment may show different degrees of formality and complexity. There are no direct links between these separate elements; they may blend in unique and different ways at each assessment, and the various policy and nursing ideals (detailed above) may apply at any stage.

Purpose

The purpose of needs assessment varies according to level; one major reason for assessing population needs is to plan service provision (Ovretveit 1993). As noted above, health commissions and GP fundholders are expected to assess the needs of the populations they serve, and set contracts with service providers to meet those needs. The idea is for service specifications to set out which needs are to be met under the terms of the contract; there may be a variable degree of precision or flexibility in the contracts (Audit Commission 1996). One health visitor explained, for example, how their contract was both specific and facilitative, presuming that a planned service provision may vary following an initial assessment:

> '. . routinely, we are doing new birth visits and we are doing screening of 7-9 months and the hearing tests and developmental assessments, but we are also doing follow-up visits that we feel are needed. We're not doing routine follow-up visits to all families but we are doing selected ones . . .'
>
> (HV3 Case M)

Thus, at an individual level, one function of needs assessment is to access service provision; this may apply to people being assessed formally under the NHS and Community Act or, as this excerpt suggests, to other services.

At its most formal, the 'policy' view of assessment appears to correspond with the idea of a 'medical diagnosis' which, once made, informs the next step of prescribed treatment - in this instance, some form of 'package of care' (DoH 1989a). There are similarities between nursing assessments and medical diagnosis in that both are aimed at gathering and organising information, then provide some form of prediction using professional judgement (Crow et al 1995). Notwithstanding the similarities, Crow et al go on to point that there are significant differences, with nursing assessments focusing on providing an accurate picture of the person's current condition and needs, and on monitoring how the situation changes. In this formulation, assessment is seen as part of the whole nursing process, rather than separate and distinct as required under the NHS and Community Care Act.

> 'There's always something that needs to be looked at again, or something's changed . . . ' (DN3 Case P)

Furthermore, the data suggested that assessments might be made in relation to transfer between services or members of the care team - when making, receiving or planning referrals (within and between agencies), or prior to delegating activities, perhaps in a skillmix team. The role of care management was acknowledged as separate and distinct in this regard:

> 'A care manager's needs assessment is different . . . it would be a more formal assessment; you're assessing the situation and the client as to what

> services you can put in. Once services are established - re-assessment, re-appraisal follows - it's more informal.' (DN3 Case N)

The extent to which nurses were expected or permitted to carry out the role of care managers varied; this will be considered further. It can be seen that local protocols and working practices may influence (and be influenced by) the various different purposes of needs assessment, whether they are formally recognised in service specifications and local interagency agreements, or not. In turn, the protocols and procedures will influence community nursing assessment practices; the extent of this impact, and the part played by practitioners in developing them, will be considered below.

Formality, specificity and complexity

Assessment may vary in the degree of formality and specificity accorded to the event, regardless of the level (individual person, family, whole population etc). At the most formal, the idea of 'needs assessment' has been closely associated with the specific assessments laid out in policy (eg, Disabled Person Act 1986, Children Act 1989, Community Care Act 1990, Education Act 1993, Carer's [Recognition and Services] Act 1995) in which certain procedures are to be followed in order to identify which services should be provided for the consumer as a right. To some extent, the phrase has, itself, become so closely linked with these specific, formal assessments, that any other interpretation would be considered inappropriate by some individuals. However, assessments vary according the degree of complexity: single or specific issue, multiple issues, interlinked or interdependent issues.

Quite often, the more formally defined assessments would be concerned with complex needs, perhaps involving a family (parents or carers, for instance) rather than one person, although a single issue may still lead to a formal assessment in some circumstances. Being 'formally constituted' tended to refer to requirements, responsibilities, protocols and documentation; it does not necessarily designate the style of assessment. Issues like ensuring clients are at their ease relaxed is stressed in the guidance for implementation of the NHS and Community Care act, regardless of whether it is a single or complex need, or whether interagency involvement is required.

The SSI guidance (SSI 1991) suggests a framework of six levels of assessment. These range from a 'simple' assessment where needs are easily defined and provision accessed from a single, existing agency, to a 'comprehensive' assessment, where needs are mulitple and ill-defined and resulting provision requires input from multiple agencies, reflecting exisiting and/or new individual combinations of services. In addition, there is a legal prescription that where a person is 'disabled' under the terms of the Disabled Persons Act 1986, the local authority is required to offer and comprehensive assessment irrespective of the scale of the need that is initially presented.

Formally constituted specific assessments are also required under the Children Act 1989, with which the health visitors were generally more familiar; here, considerable importance is attached to the idea of 'working in partnership' with the parents. Such assessments, like their counterparts in the Community Care Act, require inter-agency collaboration and follow rules or protocols which would be specified in policy at a local level. As will be discussed further below, only one such formally constituted joint needs assessment was witnessed across all four cases, and a total of 124 observed visits.

Figure 9.1

Types of Needs Assessment

Degrees of Complexity	**Degrees of Formality and Specificity**	
	features along a continuum:	
- single or specific issue	**from**	**to**
- multiple issues	- very formal	- (purposefully) casual informality
- interlinked or interdependent issues	- specific, 'hard data' - measurable, objective	- general, 'soft data' - subjective and 'intuitive'
- link with perceived severity or urgency		

However, other assessments appeared 'formal' to the practitioners. The term was not in wide usage, but it did appear as a description of a specific, focused assessment, possibly using a particular assessment tool. This health visitor distinguished a formal assessment from the 'usual' on-going assessment which occurred continuously.

> HV: I suppose it is definitely assessing because its assessing all the time, but I wouldn't say its a formal needs assessment. [. . .]
> *I: So what sort of situation do you think you would do that kind of what you call a formal needs assessment?*
> HV: I would certainly do a more formal assessment if the mum came to me and said something was worrying her, something's a problem, or if there was something that I felt was a problem (HV5 Case M)

Such distinctions were made at all levels, from individual through families and including wider caseload or community profiles. At the most 'informal' end, the practitioners used far softer terms such as 'noticing', 'picking up on' and 'just listening'; even so, they were clear that this activity constituted a type of needs assessment.

> 'Um, as I say, that needs assessment is ongoing really, um, J______ 's had a lot of a problems since when I came on the case in November and um, she's one I sort of picked up as not really having any intervention at all, [. . . .] and there's a lot of social stresses in her life, I don't know if you noticed at all but I noticed there's a new hole in the living room door um, which had appeared but um, I don't ask her about her relationship with her husband and she, she said I think he's alright the last time he visited a few weeks a couple of weeks ago.'
>
> (HV2 Case M)

Indeed, in some situations a deliberately relaxed stance - almost bordering on the 'casual' would be adopted, perhaps as a means of allowing the client the opportunity to decide whether or not to raise an issue. Again, the practitioners were clear that this still constituted a type of needs assessment, although some recognised that it may not be acknowledged as such in 'purchaser requirements' if protocols became over-specific; it was clearly of a different order to the kinds of formally convened interagency assessments required for the NHS and Community Act.

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Within the observations, the assessments varied through a whole continuum from very formal to extreme informality, from the general to the very specific and the whole range of complexity from simple, single issues to the multiple and interlinked.

> 'Well, you walk in through the door, it's a nice new door, it's nice new windows, it's a council property.... so it's not necessarily a reflection on their wealth. You look at Bob, he's well dressed, and he looks after himself, he's able to look after himself. He's also able to care for her, to a certain extent,. . . . I mean, he wouldn't be able to give an injection . . . . And the thing that struck me the most was that she was upstairs in the bedroom, and she was in her nightdress. And I had mentioned it to her, saying to her, don't you feel that you should get dressed, it might make you feel a bit better. In her periods when she's been low, but she's said that she doesn't want to, she wants to be in her .... They had a shower fitted, so they've had services before, and they've got a lift, now she's got a lift downstairs, so people have been involved before I came along. At the time I first saw her, she was very incapacitated with her arthritis, and wasn't moving, and she still doesn't know how she fell out of the bed, or what she caught her leg on. So she was like, not really with it, so the hospital appointment came just at the right time. But she was obviously well cared for.... I thought maybe it was getting a bit strained, because obviously by that time Bob wasn't feeling very well himself, because he was building up for cholecystitis, he had gall stones'
>
> (DN2 Case L)

> 'with the information we've got, we know they're young, the date of birth and we know that we're not really going to get - we are just going to take sutures out of somebody and we know for a fact there won't be many problems . . .'
>
> (DN1 Case M)

Indeed, a similar diversity of description was applied to the approaches used within profiling activities, such that the research team distinguished between the idea of 'intuitive profiles' which remained at an impressionistic level, unchecked against any harder data, and the more formally constituted ways of collating community or caseload-wide information.

> 'Well I mean, you can do needs assessment on an area based on census material and thats broadly ward based, but the sort of information we carry on our records of clients and families is a very much up to date detailed analysis of peoples needs and I think that sort of information is the closest you will get to a snapshot picture of an area at any one time.'
>
> (HV3 Case P)

Occasionally practitioners tried to integrate both forms of information, to build a clearer understanding of those they saw:

> 'I was looking at C_____ Town then, because the area was C_____ Town, it overlapped a bit, and the statistics weren't really . . . were telling me one thing, and what I was actually seeing, what I was witnessing, on I would say the majority of occasions, didn't tally. The statistics were saying to me that there was this really poor area, and what I was seeing was that these people - they weren't millionaires, obviously, but they were quite comfortably off, really. . Their poverty is to a certain extent hidden, they don't show it a lot, really. They would manage on what they'd got.'
>
> (DN2 Case L)

Perhaps unsurprisingly, this diversity of assessment approaches did not always fit neatly into the local plans and service specifications.

GAP TWO: POLICY INTO LOCAL PLANS GAP

This gap considers what happens to the policy ideals as they are translated into local plans for practice. These are represented in service specifications, protocols and procedures and local interagency agreements; for student need, it is the way educationalists interpret the policy that will appear in the planned curriculum. The emerging themes in this area begin to demonstrate the cumulative nature of the 'gaps', since issues already highlighted recur but at a somewhat more localised level.

Specifications for needs assessment

Practitioners attempted to take account of the perceived complexity of need when making their assessments, but this expectation was not necessarily helped by descriptions of needs assessment within policy. However, the policy emphasis on the separation of assessment from the delivery of care conflicted with the 'holistic ideal' beliefs held by practitioners, who stressed the idea that needs assessment underpinned the whole of practice and could not be separated from it.

> 'Everything I do is looking at needs' (HV2 Case P)
>
> 'I think you're always . . with observation . . assessing somebody'
> (DN2 Case L)

There was great suspicion about whether service specifications would really reflect the clients' view of need:

> 'are we looking at the clients needs as what the client sees as need, or from the trust . . . . are we looking at it from the point of view of figures or are we looking at the needs from the clients perspective - that's what I was looking at.
> (HV1 Case M)

The power of GP fundholders to decide which needs they would choose to purchase was another cause for suspicion, and a few practitioners were able to specify assessed needs which had been brought to their attention yet had been excluded from contract specifications. However, there was also optimism about the potential for this to change in future:

> 'you can have the skills to do a caseload profile but I'm not sure how much credibility it has with, like, the GPs as things stand at the moment. But I think they are getting more and more that because they are having to reach certain targets they need to use profiling skills within their practice and hopefully they will identify us as the people with the skills to do it . . ' (HV4 Case M)

The emphasis in contracts on quantification, statistical data and links with workload seemed to contradict the variability and sensitivity required for assessment. At times, they were clearly linked with availability of goods or services for clients, as in the application of a pressure sore risk scale, which is of doubtful validity (Edwards 1995) but still widely used for allocating equipment:

> 'You will get a pressure mattress if your Waterlow score is below 14'
> (DN4 Case P)

In general, regardless of whether the service was 'officially' required or available to meet needs, it was often the resource position which determined whether help would be forthcoming. At times, practitioners felt 'caught' between clients and management, having to explain away service shortcomings which they recognised but were not supposed to admit:

> 'care is supposed to respond to a client's needs but it doesn't work that way. If the patient's needs don't fit into a certain category sometimes there's a problem with actually meeting that need' (DN4 Case N)

> 'Yes, I've found that I've become very assertive since I've come into this job . . . . I've felt very much stuck in the middle because I was trying to do for this family and I would have to go back to them and without wanting to be too pessimistic with them or make them feel that there was no way they were going to get it - but on the other hand, you can't lie and say that yes, I've got this, because I didn't know whether I would get this help for them or not' (DN1 Case L)

Thus, despite the apparent policy commitment to providing services which are responsive to needs, the way this policy was translated into local strategies seemed to convey a more mixed message which may have stemmed from the difficult resource situation; perhaps only needs and views which were somehow 'approved' would be prioritised. This tended to be reflected by a sense of powerlessness and inability on the part of practitioners to influence priorities, which featured in some of the data, although some seemed merely to have not thought of it.

> 'I haven't said to my manager so perhaps I'm at fault for not having passed that information [about unmet needs] to my locality manager. I suppose she feeds it upward' (DN5 Case N)

The contracts and service strategies appear to have been devised in all four cases without reference to the practitioners who would carry them out in practice. A minority of the practitioners were fully aware of the policies to which they were supposed to be working.

> 'they're actually updated every year, like a children's plan, we've got quite a bulky document that we all get, so we have sort of documents which outline what is being done now and what the plan is for the future, what sort of things we are aiming for (HV5 Case M)

Fewer practitioners still described any actual involvement in the development of strategies, and some did not want the responsibility. Of course, the practitioners were still 'neophytes', in that none had been qualified more than nine months. However, the flattening of hierarchies above the G grade on which most were employed suggests that few can expect to benefit from much managerial support (particularly in their own professional discipline) for long. In 1994, a survey of practising health visitors suggested that 34% were two levels away from chief executve, but some 7% were only one level down (Durdle 1995). By 1996, this trend towards devolving all management responsibility directly to integrated nursing teams and primary health care teams appears to be gathering pace. In Oxfordshire, for example, all management functions (including financial and employment responsibilities) have been devolved to community nurses within 88 integrated primary health care teams; five experienced faciltiators are available for advice and guidance if required (Dauncey 1996).

To some extent, too, the data suggested that those practitioners who appeared the most articulate, confident and self-empowered in the interviews were also those who had contributed in some way to policy development - even if only through commenting on a draft proposal sent out by a working group, for example. Of course, if a causal link exists, there is no way of knowing its direction; that is, whether the confidence leads them to contribute to policies, or if contributing gives them confidence. However, it was noticeable among health visitors in the one case which had a specific, highly reflective and experiential module geared towards developing 'professional artistry' once the student had qualified.

The lack of involvement in the contracting process may also have been a cause or consequence of the low motivation some felt about caseload profiling, which will be considered further under 'gap 3'. Nevertheless, a number of practitioners recognised the relevance for their clients of aims and targets established at trust or purchaser level, and sought to influence the process by which these were established. Purchasers and managers did not necessarily welcome this involvement, nor information about unmet needs in their areas. In other places, this was encouraged as a means of combining the most up-to-date information with published data.

> Well I mean, you can do needs assessment on an area based on census material and thats broadly ward based, but the sort of information we carry on our records of clients and families is a very much up to date detailed analysis of peoples needs and I think that sort of information is the closest you will get to a snapshot picture of an area at any one time. . . . the Trust encourages us to do neighbourhood profiling and practice profiles, but we are not expected to do caseload profiles. (HV3 Case P)

In general, questions about compiling profiles of health need gave rise to a huge variety of responses, some of which reflected the different approaches, learning and demands on the practitioners' time, which will be considered further below.

Representing consumer views

Despite the idea that community profiles might be used to represent consumer views at a contracting level, in general, they did not meet the quantitative, specific requirements of contract data. Rather, they attempted to take account of the variability of need and different consumer perceptions through 'soft', sometimes intuitive, data accumulation. In some cases, this appeared to be because it was considered sufficient by the practitioners who felt they were closely 'in tune' with the needs of the population they served. At the other extreme, and as presented in some college learning exercises, profiles may consist of caseload numbers, supplemented by statistical data, which 'averaged' community need too indiscriminately. Also, a number of practitioners were asked to submit aggregated contract targets, which seemed unrelated to the individual needs assessments in which they were most interested. This, combined with limited feedback from managers, led to some cynicism about how the data were used:

> 'It's more a profile of work done than a profile of the health needs - actually, a list of the work done in retrospect. It doesn't provide for health needs. It's a different way. It would be interesting to know if they use that information as the base of how they organise the services . . . that's partly the aim of it in the first place. The government wanted these figures, presumably to know how they could better cater for the health needs of the nation. Its not how it's working . . . ' (DN5 Case N)

The district nurses generally felt they were already fully occupied in responding to patients who were referred to them. Even so, some still felt profiling had some value, either in order to identify unmet health promotion needs or to more closely identify with the community they served:

> 'I mean it must be [useful in practice] because you want to know more about the community that you're trying to serve. How, except this? We see people who are referred to us, so we are limited by that, so we don't know what else. If, I mean, it is a community profile, but unless people are referred to us we are not going to see them' (DN3 Case L)

Health visitors seemed more likely to acknowledge that an 'intuitive basis' for profiling was insufficient alone, yet they were not afforded the time to carry out the more formal data collecting and analysing activities required; this was a source of considerable frustration for some:

> 'I mean, really, when you think about it, how can you health visit in an area if you don't know what the really big needs are? and I'm still struggling to try and get together the infomration to do that community profile so that you know you can be quantitative as a whole, you know, and how can you help this community improve their health and well-being? Realistically, you come into the office and a pile of paperwork and a pile of visits and clinics to run . . [. . .] unfortunately the community profile ended up being something I do in my own time' (HV3 Case M)

Consumer views about their needs could be identified at a number of levels apart from that of the community profile, and through various different approaches to needs assessment. The wide diversity of assessment situations observed and discussed during data collection were not fully evident in the curriculum documents, although each course had its own approach to teaching needs assessment. In most cases, the approach differed widely between the health visiting and district nursing courses, even within the same college.

On the whole, the district nursing courses emphasised the use of nursing models to structure assessment; this was less common in the health visiting courses. The models used tended to reflect an individual - rather than family or community - philosophy. In the health visiting courses, family and community issues were more widely expressed within the curriculum documents, and were taught more often within the framework of the principles of health visiting than through the use of family or community nursing theories; there was greater emphasis on policy and political matters than for the district nurse students.

The limited extent to which some practitioners had learned about the centrality of needs assessment in the NHS and Community Care Act was quite worrying. There was a feeling from Case M that the district nursing students were expected to know about this before they came on the course, while in Case N one even admitted,

> 'I can't remember learning anything about joint assessment. I did not know needs assessment and care management were drawn from the Community Care Act - I haven't been in this job long enough' (DN6 Case N)

A lack of up-to-date reference material in relation to the Act was noted in all the curriculum documents, even in Case L, which was the most recently validated of all the courses (1993). In Case P, there was a feeling that, while it was over-taught to the point of exasperation, the practitioners still considered the depth of understanding they had acquired about it remained fairly superficial. It should be acknowledged that it is unlikely that any of the college lecturers had any experience of practising as community nurses under the new working arrangements themselves, so were likely to be at something of a disadvantage.

Figure 9.2

Teaching Needs Assessment

Case	District nursing courses	Health visiting courses	Common core
P	emphasis on developing expertise in assessing individuals	searching for health needs, health assessment skills, need identification; assessment of need, screening and surveillance	sociology/social policy: needs, wants and duties
N	to undertake 'placement profile'	collective needs assessment; to undertake 'placement profile'	resources, finance, control; to develop information package on community resources
M	to undertake neighbourhood profiles, needs assessment not specified; holistic concept of patient care stressed; skills of making referrals	to profile needs of individuals, families and communities; assessment linked to 'principles of health visiting' models of assessment; systematic approaches to receording data	social environment and family; experiential learning
L	assessment through nursing models and how to use assessment forms; profile to be drawn of practice setting	policy/political nature of needs, needs assessment; profile to be drawn of practice setting	Social policy Health promotion

Specifications for Joint Working

The policy ideal of collaborative and joint working across health and social services presupposes agreement on respective agency roles in assessing and meeting need. There appeared to be a lack of clarity and some ambivalence regarding this on the part of practitioners; not all were aware of the community care agreements which should have been in force by the time the data were collected. Indeed, some were quite emphatic that these plans were not working, and that it was up to 'the managers' to sort it out:

> 'We don't have team meetings ; we never meet up; we never see each other [. . . .] This is a management thing, but the nursing managers aren't strong enough; there are managers who just won't listen. [. . . .] It needs sorting out from the top down. There's nothing we can do.' (DN4 Case N)

Indeed, there was some evidence that health and social services had not fully established guidelines about joint working, particularly in their respective responsibilities and resource management strategies, which in turn influenced needs assessment practice.

> 'What I find frustrating is that ..we get a referral and we'll respond, in 24 hours depending on the urgency, and you refer to these other agencies.. especially social services, someone just turns around and can see it's a social need, and

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> they say well there's not the resources. And well it always just falls back to us' (DN4, Case L)

The lack of agreement about service specifications for joint working has been found by Hardy et al (1993) and Bewley and Glendinning (1994). Bland (1994) argues that this is largely dependent on past levels of joint working, and as such have not yet effected change. In Case L, the difference between policy rhetoric and practical realities for practitioners could be frustrating and disorienting, leading to a degree of cynicism. The same district nurse shows how ill-equipped she was to effect change to her client's care package:

> 'I just felt, well this has gone on for so long and I needed to try also to speak up for Lucy as well. . (but) no I didn't . . I suppose other anxieties about the meeting today, and you just get so...in the time you just deal with those, but it really does wear you down. . . It really frustrates me thats all, I won't deny it' (DN4, case L)

In the only joint assessment visit observed during the study, the interaction between social worker and district nurse was characterised by the practitioners' similar lack of power to effect change, or design a care package, because the health and social service agencies had not yet established agreed methods of working. Managers within the social services in this borough had set a date some months in the future when they would have a strategy for joint working fully established in which clear areas of reponsibility would be outlined.

In the interim period, both health and social services practitioners could only refer to a sub-committee whose task was to deal with urgent cases, making provision where necessary. The result was a long and complex procedure of assessment at various levels in the two organisations, with much cross referral at each level. Decisions about clients were often deferred, and practitioners were left to make ad hoc arrangements, with no associated budget.

The practitioners appeared to have little influence on the way interagency agreements were established in any of the cases. There were more views expressed about care management in Case N than any others, perhaps because it was gradually being implemented across the area at the time of data collection. Interagency communication problems were firmly attributed to management inaction, and linked with a perceived lack of respect for nurses' professional judgement from social workers.

The practitioners claimed to have learned nothing about care management in college, but a great deal of work had been undertaken in the trusts to help staff to become ready for this new way of working. Inevitably, as in any new service, the responses were mixed, with positive and negative experiences being outlined with almost equal vehemence. The formality of the assessments could seem intrusive, compared to the gentler nursing approach:

> 'Care management sometimes, if you need a service straight away, you're having to ask intrusive questions and find out a lot more on the first visit than you would if you were actually going as your district nurse role. It can give the patient a very different idea of what, what district nurses are about it didn't give you the time to build up some sort of a relationship you have to explain why, why you're actually filling these forms out, that they do understand. It doesn't give you the time to build up trust - to be more comfortable in talking to you.' (DN4 CaseN)

'Community care' was described as something of a 'takeover' of what used to be in the nursing domain by social service workers, whose credentials for holistically assessing their patients' needs were clearly doubted by some district nurses; this feeling was expressed in other cases as well. However, some recognised that the feeling could be reciprocated, with social workers feeling equally 'invaded'.

> '(Director of care management) does not want district nurses involved in this assessment; he sees it as a social work prerogative and does not want us invading their territory' (DN3 Case N)

Formal allocation of responsibilities between agencies through joint protocols and working strategies has an impact on the perceived power balance between the professionals concerned; it may be related to resource availability.

> 'I think Social Services were loathe for nurses to be able to allocate parts of their budget and vice versa they weren't happy about that idea, of us being able to have a say over their budget and what is to be spent.' (DN6 Case N)

In this case, there was a view that the most suitable care manager should be chosen according to the client's overall needs, but this did not take account of the power balance:

> 'The care manager is determined by their social worker and their social needs entirely, I mean entirely.' (DN5 Case N)

Only one formally joint assessment was observed, and the extent of experience of this method of working seemed very limited in each of the case study sites.

> *Int: Have you been involved at all in joint assessment?*
>
> HV: You mean with another member at the same time, going along together and assessing? Not at all, I haven't done any of that and I haven't heard of anyone else that has done. (HV4 Case P)

However, despite a scarcity of formally convened joint assessments, collaborative opportunities arose within and between agencies in other cases. Policies for working together applied in a range of situations, and some trusts appeared to have made more progress with these plans than others:

> 'you know we have what we call a 'working together' document which is like a policy document which we all get copies of and it is about working together in terms of seeing how we can improve the health care planning, that sort of thing . . .' (HV5 CaseM)

There are two issues to be considered here. The first issue concerns the extent to which, when students or even after qualifying, these practitioners were able to gain experience of joint working, particularly for formally convened assessments under the NHS and Community Care Act. The cohort who formed the sample for this study began their training during September 1993, a year after the Community Care part of the Act had been implemented for the first time; this may account for the dearth of learning experience. However, the data were collected nearly a year later, and it seems surprising that two years after implementation there was still little joint assessment in practice.

Second, sound protocols and well laid inter-agency plans will undoubtedly help facilitate collaborative working, but poor ones can be a hindrance:

> 'Social workers have got a budget and they can offer so much care and they can be reluctant to offer any more, because if they need to offer any more they have to put the case to a panel and they have to have a nursing assessment as well and they are sometimes reluctant to do that' (DN3, Case L)

However, their existence appears not be something over which practitioners have any control. Nevertheless, some practitioners were simply not prepared to be 'obstructed' - if their clients needed collaborative working, the practitioners made a point of seeking out colleagues either face-to-face or on the telephone; in other words, they took control of their own working practice, regardless of the management stance.

All the curriculum documents referred to encouraging joint working, and there did seem to be great deal of commitment to it as an 'ideal' - but not everyone felt sufficiently empowered (perhaps because of lack of confidence, time or commitment) to overcome barriers which they encountered. Some strategies which were used successfully in practice will be detailed in the next chapter.

10. TIMING OF NEEDS ASSESSMENT

The preceding sections have related, first, how the rather abstract 'pure' concepts represented in the ideals of needs assessment are translated into policy at a national level, setting up a requirement for community nurses to learn how to practice according to this 'new approach'. Second, community nursing is affected by (and potentially able to affect) the way these ideals are translated into operational strategies, policies and specifications for services locally. Understanding of the types and purposes of needs assessment at the many different levels is required by both service planners (purchasers and providers), and the community nurses who will operate the plans in practice. In many respects, the successful implementation of needs assessment into practice depends on ensuring an appropriate approach is used, according to timing aspects of needs assessment.

'Timing' emerged in various different important guises in the data (Figure 10.1). Some of these issues are related solely to needs experienced by the client. However, most are intertwined, and indicate some of the sensitivity and skill required to elicit needs in the practice situation; they demonstrate the link (and potential for conflict) between timing issues for services and for clients receiving them.

Figure 10.1

Timing of Needs Assessment

client issues	service issues
• past: identifying history, culture, background of client, in personal/individual terms • present: immediate or current actual need for service • future: potential needs, planning ahead, in terms of health promotion and preventive care - both for individual clients, and for service • timing assessment to accord with clients perception of need, and their readiness to discuss • urgency of response required	• achieving service requirements: eg, policy aims and annual targets • facilitators and constraints; quality indicators, charter requirements, waiting lists etc • planning ahead - at level of whole service, or local team (eg, delegation and skillmix issues; prioritising within caseload)

practice issues
• assessment as a single event, or a continuing process • time as resource for client or service • sensitivity and skill of the practitioner to mediate conflicting demands

The issue of separation or integration of assessment has featured before, in considering whether it is really possible to distinguish between health needs and social needs within the client context, and of the benefits or difficulties of separating

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assessment from the delivery of care. Indeed, practitioners found difficulty in coming to terms with the apparent contradiction in policy which required that needs assessment should be client led, but also that service provision, based on this assessment, should be 'tailored to individual requirements' (SSI, 1991, p.13).

Here, a related issue surfaces, regarding whether assessment can realistically be considered a separate event at all, or if it is continuing process. There was little doubt in the minds of the practitioners, who described beginning the process of assessment as soon as they received information about new clients, and felt it continued throughout the time they were involved with them:

> 'I had already started it (assessment) before I even go, because I'm looking at the address and thinking, right I know which area it is, so you're sort of thinking - you try not to be judgemental about people but you're sort of gaining a picture before you go . [. . . . .] . I think assessment is right from, you know, I started assessing that family and I will continue assessing however long I'm visiting . . . ' (HV3 CaseM)

> 'I think it's a continual assessment, whenever you go to see a client you are assessing and re-assessing the whole situation, it's continuous, it's not something you think about to do. [. . . . .] Today the fourth one, it was thought about, it had to be done, it was more of a formal assessment. The other three, it was like a re-assessment, more informal, but it's something as District Nurses you do continuously without even thinking about it, you don't put labels on it, you just, it is part of the job, you re-appraise the situation continuously.' (DN3 Case N)

There was little difference of opinion about this; assessment was undoubtedly viewed as a continuing process. Indeed, practitioners conceived of assessment as the prelude to involvement in care rather than disengagement, and it was often conceptualised as part of that care. There were exceptions, to be considered below, when clients were to be referred to a different service and simultaneously discharged from the community nursing caseload. However, referrals were often linked with sharing of care and responsibility, rather than simply 'handing over' and withdrawing.

The perceptions expressed in the interviews were largely corroborated by the observation data, which demonstrated that only a minority of assessments were designated as 'complete' by the observers (Table 10.1). In most instances, too, a follow up of some kind was arranged, although this was sometimes an arrangement to meet up at clinic or to make contact by telephone. The concepts of 'complete' or 'incomplete' assessments are necessarily subjective because of an element of evaluation; they are not only open to multiple interpretations depending on whose perceptions are being sought, but may also indicate usual working practices as much as 'what is possible'.

There was, for example, no immediate correlation between whether a visit was designated as 'complete' and whether a follow up was arranged or not, partly because a number of assessments were being carried out on behalf of colleagues, perhaps to cover sick leave or a vacant caseload for example. In those instances, the practitioner might make further arrangements, or may leave them for the colleague to deal with on return. In a study of team working among district nurses, Griffiths and Luker (1993) identified a sense of 'etiquette' that could inhibit practitioners from reaching firm decisions which would bind their colleagues to a way of working on their return; an alternative approach would be to leave some aspect of the assessment 'open' to be picked up later. However, the very difficulty of being certain about distinguishing and separating assessment practices in order to observe their completeness suggests that assessment is intimately intertwined with the whole process of the community nursing practice; this will be discussed further below.

The second issue which has recurred throughout the analysis and which appears once more in this section, relates to the resources. Here, it is time as a resource which may be used to give attention and care to a client, or which may need to be conserved for other priorities within a pressured caseload. Indeed, shortage of time to offer clients the kind of service which seemed to be merited according to their assessed needs was, perhaps, one of the most enduring features in the data.

Table 10.1

Assessment as a Continuing Process

Case L	apparently complete	apparently incomplete	not classified/ unsure	follow up arranged	follow up not arranged	not classified/ unsure
first visit	8	0		8	0	
subsequent visit	13	17	2	30	0	
Case M	**apparently complete**	**apparently incomplete**	**not classified/ unsure**	**follow up arranged**	**follow up not arranged**	**not classified/ unsure**
first visit	4	9		10	3	
subsequent visit	4	10		12	2	
Case N	**apparently complete**	**apparently incomplete**	**not classified/ unsure**	**follow up arranged**	**follow up not arranged**	**not classified/ unsure**
first visit	7			6	1	
subsequent visit	4	16		16	2	3
Case P	**apparently complete**	**apparently incomplete**	**not classified/ unsure**	**follow up arranged**	**follow up not arranged**	**not classified/ unsure**
first visit	6			5	1	1
subsequent visit	20	3	2	19	2	3

> 'I'm very hard pressed just to do the basics. To mind, it is very, very basic; I'm conscious of lots of things I want to do, and I can't do them . . '
>
> (HV1 Case M)

> 'I always think that I could be doing more, that's what makes me think that I haven't done enough or there should be something else I could be doing. . . which doesn't always happen because you haven't got time to do that for each individual child when you've got a caseload this big'
>
> (HV1, Case L)

> 'Marie Curie Nurses are available to sit with terminally ill patients overnight and sometimes through the day, but they are only available about two or three nights a week - that's not determined by the client's need. [. . .] The cost is a major figure in determining what client's are saying they need, but they can only have her two days a week because of the cost. There are huge gaps between things we assess and the services that are provided.
>
> (DN6, Case N)

> 'That took hours of time - we were whizzing around seeing other people because we were so busy' (DN4 Case P)

Important though it is, the challenge for community nurses who assess needs in practice is not merely one of time management. The timing requirements arising from different levels of awareness in clients, of meeting the assessment agendas of purchasers and those arising from needs on their whole caseload, and of maintaining smooth working relationships with colleagues, require an ability to achieve both a clarity of purpose and a breadth of vision. The practitioners not only need to learn about the service specifications, formal documentation and officially established policies; they must also face the daunting task of translating them into a service provision which achieves the desired quality of needs assessment for clients.

GAP THREE: PLANS INTO PRACTICE AND TEACHING

This gap focuses attention on discrepancies between, on the one hand, service specifications and actual service provision and, on the other, curriculum planning and the learning which actually took place. As the issues highlighted in 'gaps' one and two are revisited from a less abstract and more practice-based perspective, the impact on service quality is not merely cumulative. A number of apparent contradictions and practical dilemmas (and in some instances, their solutions) begin to emerge.

Learning about needs assessment

Notwithstanding the rather static and singular view of 'need' and 'needs assessment' assumed within the purchasing requirements of the NHS and Community Care Act, the variability of 'needs assessment' in practice was apparent across all four cases. The range was not only related to the needs of the clients (which were hugely diverse, even within the distinct disciplines of health visiting and district nursing), but also to the types and kinds of assessment. Teaching must necessarily be diverse too, since there cannot be a single 'right way' to assess. There seemed to be four main approaches; developing communication skills, nursing models, other systematic approaches and general professional development.

Interpersonal ability was acknowledged throughout as hugely important for assessment; students were all offered some kind of tuition in communication skills. The manner in which this was presented differed, with terms such as 'counselling' and 'psychology' being used; the perceived success varied between sites and students as well. It was not universally either well received or well taught, possibly because the topic itself is very sensitive, individual and personal - a point which was not lost on the practitioners.

> 'Communication and life skills are quite sensitive skills but I'm not sure about learning them in the course, [. . .] inevitably people had personal problems, lecturers were completely unaware of and people were exposed to, to very difficult situations who should not have been, [. . .] he (lecturer) got very, very angry about it, very - people should have been protective about that'.
>
> (HV5 CaseN)

> 'Interpersonal skills are something learned through experience, rather than education'. (DN1 Case P)

Despite their doubts, most of the practitioners appeared to have grasped the essentials of communicating in a sensitive and empathetic manner; they acknowledged the importance of these skills through the whole of their practice.

> 'I think the communication side of things, both verbal and non-verbal, is quite crucial to an assessment' (HV4 CaseM)

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All but the briefest visits were thought to be about assessment to some extent, and practitioners in all four cases identified the partly 'intuitive' and individual nature of assessment, with an emphasis on communication skills, timing of questions, taking note of changes and being aware of clients' priorities.

> 'a lot of things come up when you're just chatting. You need to be a good communicator - to form a relationship - allow them to feel comfortable to disclose information, to adjust to your conversation. You pick up whether they're uncomfortable about you asking questions' (DN2 Case P)

The importance of planning for future and health promotion needs appeared particularly relevant to health visitors, although some district nurses also noted this need:

> 'Yes I think needs assessment is, is looking at the family's health, um, that's holistic [. . .] and then make an assessment of the needs, um, which can be present now or that may be present in the future that they can maybe use in preventative method to address now, that's how I see it.'
> (HV2 CaseP)

Likewise, knowing a person's background and past history can be extremely important in planning present interventions:

> 'You have to marry what you think would improve their general condition with what they feel is necessary. It would be quite difficult to do if I hadn't met him before and didn't know his background, in which case referral to a learning disability nurse might be appropriate'
> (DN2 Case P)

> '. . it turned out that there were all sorts of er problems in her own life which were impacting on her relationship with her husband and their relationship with the children and she had not realised but she thought it was just one of those things and she just had to live with it. [. . .] I think it has to be done very gently because er, we want to work with clients and we need to maintain their trust' (HV2 Case N)

This softer approach extended beyond individual assessments, to include an 'intuitive' awareness of needs within a caseload. As explained above, in most instances these impressionistic profiles had not been checked against formal data, being expressed rather as 'being aware of', or 'having a feel for' what was happening in the community. One health visitor had asserted, for example, that there was reason to be concerned about nutritional standards in clients on her caseload:

> *I: What has led you to believe there is a, where do your concerns about the diet stem from?*
> HV: Yes, I suppose it is largely ad hoc, its not precise data and if you like its a subjective opinion that, you know, I obviously do discuss what families have in their diet and it is a broad opinion about what there is and what the family have and what they don't have, particularly amongst the families I see perhaps more regularly than most. (HV3 Case P)

The use of nursing models as a basis for assessment featured through all the cases, although they were emphasised less and were somewhat less popular with students from the health visiting courses.

> 'I suppose I was a generation that trained before models um, and therefore tend to find that to some extent I feel some nurses today tend to fit the patient

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> to the model rather than the model to the client and you're the wrong way round - and that worries me about the use of the models. I think they are taught but I think it can be a bit over done, I think it's important to clarify one's thinking but not to get too hooked up on one but to use as a thinking background'
>
> (HV5 Case N)

The only exception appeared to be in case M, which taught their use through the 'Worcester Models' (Worcester Health Authority, undated) which were derived using an adaptation of Peplau's interpersonal relationships and Maslow's Hierarchy of Need (Maslow 1943). This explicitly includes a family assessment component, as does Clark's (1986) adaptation of the Neuman system's model (Neuman 1989) which also featured. None mentioned the use of nursing models which have been adapted for assessing community wide needs, or teaching of family nursing theories. Other general textbooks were mentioned, such as the ones by Robertson (1991) and Luker and Orr (1992), and a few said they had been taught to use the principles of health visiting (CETHV 1977) for assessment purposes. Nevertheless, family assessments appeared to be the norm.

In district nursing, the most often mentioned models were those of Roper et al (1985), Orem (1985) and Roy (1984) which are less readily adapted for family use, although the authors would claim this is possible. Indeed, the district nursing curriculum documents tended to imply a fairly singular approach to the assessment of individuals only. However, they did stress the importance of taking carers' needs into account (a point which has become even more important since the Carer's Act 1995 was implemented in April 1996), and it was clear that the practitioners did, somehow, learn to take account of both families and carers.

> Assessing the carer's needs is part of assessing the patient's needs; they're so interlinked, if you looked at a person holistically you include the carer's needs.
>
> (DN6 CaseN)

> *During the observation period, a district nurse described a situation where she had to balance a mother's anxiety about the child's ability to eat whilst undergoing chemotherapy with the child's need for the cytotoxic agent, and the resultant lack of appetite. Explanations, negotiations and reassurance were not enough to prevent the mother from withdrawing the child from treatment if his appetite became suppressed beyond the mother's ability to cope. This practitioner had learned about family nursing theories in the hospital where she had previously practised as a paediatric nurse; this helped her in her approach to caring for sick children in the communty.*
>
> (DN1 Case L)

The documentation which was used to record these assessments was sometimes based specifically on nursing models, but at other times the record itself appeared to provide an alternative structure to the assessment. These records provoked varied reactions, with some being more enthusiastic than others, and a number of practitioners describing working groups which were currently restructuring the records.

> 'I don't think the forms we've got are ideal - they don't allow for change.'
>
> (DN CaseP)

> 'at present on the notes is things like, have the family got a fireguard and what sort of house is it and we thought it would be better really if they introduced a model of health visiting. We weren't going to dictate or be prescriptive about which other people should use, so we've just basically introduced the nursing process into the notes which hasn't happened before now . . ' (HV2 Case M)

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Official records were used as an agenda for assessment in many instances, although this was not always adhered to very strictly. In general, it was acknowledged that having some kind of agenda could be beneficial, especially when first meeting clients or if there was a particular issue which needed to be considered. Indeed, some of the slightly more formal approaches to needs assessment could be used as a way of encouraging the client to 'open up'. One health visitor explained the use of an outline 'family tree' to establish which household members were related and how, and to talk through their health and encourage further discussion:

> 'if I'm doing sort of an assessment on a family I do it once or twice formally and actually say we'll go through all these different areas and another time I've done it perhaps more briefly and not quite as formal, but in my mind I've gone through, almost like a check list in my mind of sort of different areas. And its funny because you can ask them you know is everything fine and oh yes fine, but then when you start looking at different areas, a lot more comes out. Oh , didn't realise you meant that or you know relationship problems or worries about the children running on the road outside or worries about the chemical factory next door, or trying to get the parents to remove dog dirt on the path and yet they're smoking 60 a day themselves, that's a classic one that does actually happen, and I'm concerned about this poor baby in a smokey atmosphere!' (HV5 CaseM)

The application of other systematic approaches to assessment included social efficacy scales, the Edinburgh post-natal depression scale and the use of indicators such as the Bartel and Waterlow scales. District nurses (unsurprisingly) took more physiological readings than the health visitors, who mainly completed formal assessments in relation to children's weight and development. Despite using the formal documentation and trust guidelines for inter-agency assessment, most practitioners stepped outside the prescribed agenda for assessment, suggesting that practice demands more flexibility than rigid specifications demand.

Notwithstanding the dissonance between specifications and client needs and the apparently restrictive nature of some service specifications, in certain instances they failed to infiltrate practice at the level of either awareness or influence. For instance practitioners in cases L and P were either not aware of a trust mission statement, or failed to relate it in any way to practice. A parallel example from the educational dimension is the integration of the NHS and Community Care Act as a subject for study into the curriculum; a number of practitioners remembered learning little about this, displaying minimal grasp of its implications as a result. Indeed, the formal guidelines appeared somehow peripheral to the main activity of assessment, which was intimately linked with the rest of the work - to the extent that questions about assessment were often answered in terms of the whole of community nursing.

Identifying which approaches were the most suitable to use appeared to involve learning how to balance and prioritise activities across the workload as a whole, and to learn about far more than the immediate assessment activity. One health visitor covering a very large 'skillmix caseload' explained how she used a variety of strategies to ensure she met the policy requirements for contact with her clients, as well as trying to ensure she was not missing important needs, while a district nurse was acutely aware of the need to ensure her 'priority' clients did not lose out because of time restrictions.

> '. . part of it's dictated by policy and protocol and home visits are prioritised because I, my week tends - I'll just give you a breakdown of my week *(specified sessions and numbers such as attendance at ante-natal clinics, parentcraft and immunisation sessions accounting for four half days a week)* [. . .] I tend to prioritise by keeping in contact with them, with the parents on the caseload I tend to ring them or visit according to their need.' (HV2 Case M)

> 'There's only a certain amount of time in a given week, given the resources. Having said that, I don't think we stint where it's needed . . . . I'm thinking of our terminally ill patients . . . ' (DN3 Case P)

The potential for caseload profiles to serve as a tool for caseload management and prioritising in practice appeared not to have been grasped by some of the very busy district nurses, who (as shown in another study by Worth et al 1995) suggested that they could barely cope with the level of need about which they knew. There was a feeling that any hidden needs would be best not uncovered, for fear of being unable to meet them. Quite reasonably, a number of district nurses pointed out that their workload was largely determined by referrals, whereas in health visiting a more proactive approach is expected through the 'search for health needs' (CETHV 1977). Quite bluntly, one stated:

> ' we don't have time to spend sitting down looking at area needs.'
>
> (DN4 Case N)

Both systematic and 'intuitive' approaches to assessment may be appropriate at different times; the important skill for the practitioners to achieve relates to the ability to decide which is required at a given moment in time. Some cases may be dictated by the requirement for a formal interagency assessment, but in most instances some professional judgement is required from the start, to decide the best way to assess. Practitioners recognised the complexity of the knowledge required for this decision, speaking of a need to balance different requirements and perceptions. On the whole, these professional judgement skills needed to be developed in and through practice. In case M, for example, various college based assessment exercises and assignments geared towards developing professional judgement were acknowledged as very helpful, but the practitioners only realised this with hindsight, once they had gained sufficient experience to fully understand their significance.

Consumer views in practice

The need to develop a deep ethical understanding of how needs arise and might be met surfaced again when attempting to take account of client needs in assessments. Practitioners in all four cases expressed attitudes which were consonant with the policy ideals of empowering clients to make their own decisions.

The aims of self assessment, or enabling clients to make their own decisions, perhaps using client held records or educating clients and providing information on assessment were expressed in the interviews, but not necessarily observed. Having said that, some very facilitative and empowering approaches were observed in all cases, and as shown in Table 9.2, the clients views of need were almost always recognised by the assessing nurse. However, recognition of client need did not automatically translate into a situation in which the clients needs would be met; the issue of different priorities within assessments often led to complex dilemmas for the nurse.

> 'We discussed using the Dosette box and I thought he would be really pleased, but he actually said "Well, I enjoy your coming in everyday" and he was quite adamant that if you just put them in the box, he wouldn't take them. So that's very difficult, when he sees his need as different'
>
> (DN2 Case L)

Table 10.2

Recognised client view of need?

	recognised client view of need	did not recognise client view of need	unsure
Case L	35	4	0
Case M	22	2	3
Case N	25	0	1
Case P	24	2	5

Over-simplification of the notion of need within much of the policy guidance fails to fully recognise this complexity, or the different consumer views encountered in practice. Practitioners were often aware that conflicting priorities might arise, not only between themselves and their clients, but also between different household members or within families:

> 'if a family was living in squalor, then their need is probably more to, well financial need and caring for their children, making sure their children are safe, whereas my need would be well, if you improve your hygiene then your children are not going to keep getting a cold, getting infections any more - diarrhoea, that sort of thing . . . ' (HV1 Case L)
>
> 'Sometimes "A" is telling you what "B" thinks and . . it's all going round in circles. There are times when you need to get people on their own'
> (DN1 Case P)
>
> *Observation : 'The Asian mother who shyly opened the door holding her new baby clearly spoke no English at all. We did not have an interpreter with us, because the health visitor had neither met her before, nor been given any indication that the woman was unable to communicate. She beckoned us into the small living room, and vigorously shoved at a pile of blankets on the settee. After a moment or two, she pushed again, and the face of her husband appeared with an angry growl. Grinning nervously, the woman indicated to us, her guests - and he roused himself, at first truculently and then with interest. The health visitor showed her identification again, apologising for disturbing him, as she assumed he must be on night duty. No, he said; he was tired because of the baby - he glowered at his wife. His spoken English was good, and he soon aroused himself to detail his needs at length over the next 45 minutes. He was unemployed, had married beneath his caste, he said. He was considering leaving his wife and going back to the other side of town from whence he came, in order to seek work. He said, without apparently checking, that his wife had no questions so the health visitor did not need to bring an interpreter back with her - but she could return if she wished; he had enjoyed talking to her. The health visitor arranged a day, politely insisting that he explain to his wife - although she had no way of checking if her messages were accurately interpreted.'*
> (HV1 Case M)

Many examples of different priorities within families occurred, most frequently in association with revealing a terminal diagnosis or the coping ability of exhausted carers in district nursing, and in child protection situations for health visitors. There was a general belief in the value of openness, and where this was supported by official policies that could be very helpful, although the difficulties of implementing genuine 'partnership' approaches were acknowledged.

> 'It is the policy here for the mother to attend all of the care team meetings; it helps with the openness. They are aware right from the minute that you know a care plan is put into place (children being on the register) there are regular meetings and she has always been at all of them' (HV4 Case N)

There was nothing in the data to support the idea that need and needs assessment could be regarded as a simple concept or straightforward activity within the 'consumer' context; differences within families or across communities or caseloads could make both representation and practice somewhat problematical. The dilemmas encountered in practice appeared to need practitioners with the capacity to exercise professional judgement under sometimes difficult conditions, and an ability to negotiate and prioritise potentially conflicting needs, pointing once more to a strong understanding of the ethical and moral basis for their assessments.

Working together in practice

Interestingly, the kind of working together which is perhaps most clearly documented in the literature - joint needs assessment for persons with complex needs, being assessed under the NHS and Community Care Act - was the least apparent in practice, having been observed only once (in case L). In the other cases, the practitioners were able to describe experience of such assessments, but it was clearly not a frequent event in everyday practice for the majority. Health visitors related more closely to the Children Act 1989, and several had experienced joint assessments prior to case conferences as a slightly more common event. However, none were seen in during the data collection period.

Three inter-related issues recurred in relation to joint working. The first related to the status of the specifications which, as discussed above, were in different states of readiness in the different cases. Second, and possibly related to this, was the issue of trust and respect between the different agencies and discisplines. The third issue concerned the extent to which practitioners took responsibility themselves for ensuring that joint working did in fact occur, relating it to their everyday team work and working practice.

Just as there appeared to be little input into service specifications, so there was little mention of involvement in interagency agreements by practitioners. However, where protocols and policies existed, they could give rise to very positive action:

> 'You mean with care planning meetings and things? Every month we have a meeting with social services and if we have a problem we discuss the patients with social service and we found that very, very beneficial, so we're there assessing the needs with social services and ourselves, and if we had any problems we would sort them out there and then' (DN1 Case M)

> 'It's not just me, there's the whole primary health care team and other agencies; if I don't consider it's something that a district nurse can provide, social services have weekly meetings and one of us from the team attends every week, which means we can brief them on anything that needs to be clarified. They do rely on us for extra information; they're very helpful.'
> (DN3 Case P)

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However, the formal specifications for inter-agency working appeared to be still in a state of uncertainty in at least two of the cases, and much of the debate focused on specifics of which service should have lead responsibility - and bear the cost - for particular activities. The one instance of joint assessment (case L) arose despite, and partly because of, problems in obtaining interagency agreements as to service provision responsibilities.

The content of the meeting was not largely about assessment; both district nurse and social worker agreed that need existed and what sort of services should be provided. The scarcity of resources and the reduced ability of both practitioners to respond to need provided a focus to the meeting. In this instance there was a highly bureaucratic process which surrounded an acceptance of responsibility for the client. Both practitioners searched for methods of circumnavigating this by a complex process of negotiation of information. In the same way that overt representation of client needs to management requires political awareness and communication skills, practitioners liaising on a day to day inter-agency basis require knowledge and understanding of the results of policy and practice and the skills to deal with them.

Indeed, the literature suggests that the main focus of social and health service collaboration at a local organisational level is on agreeing formal guidance about which functions are performed by which agency, and the associated mechanisms (including form) of assessment (Baldock, 1993). Dant and Gearing (1990) argue that it is likely that this will lead to forms being left largely unused; discontent about the length or the formality of shared documentation was widely expressed in this study.

> 'Social Services designed the documentation; it's actually tick boxes, and adding a few comments. It is to see what the problem is and not actually looking further at the needs (DN4 Case N)

> 'Assessments for child protection are very detailed. Health visitor assessment would cover a wider range in lesser depth. I don't think documentation actually helps. It is a very basic record of your visit'
>
> (HV1 Case P)

> *Int:* *Thinking about the document you use to assess clients, do you feel its appropriate?*
>
> DN: No, dreadful. [. . .] it had no structure to it and it was just bits from everywhere, you could tell it was bits from everywhere, it had, D______ was it, it was some school, I must show it to you at the end of the day, it was a big thick thing like that to be used for every assessment which was unrealistic to start with I feel. And then there was a lot of circling and ticking which I think's just, and then you've got to score at the end of it all (DN3 Case L)

Distinctions between health and social need continued to raise difficulties, although practitioners in one case acknowledged that the protocol was usefully obliging them to examine their working practice:

> 'at one time a district nurse would literally go into any person, but now we are trying to look at is it not a nursing problem, we've got to get, we need to get social services in. So yes, we tend to say - not in all the cases, but most probably with the elderly, 'cos otherwise we tend to take on far too much and not be able to get enough to the patients who actually need us.'
>
> DN1 Case M

The presumption that division of responsibility might help to reduce district nursing overload in situations where clients who had normally featured solely on their caseloads rests on the idea that the responsibility would be passed to social services in its entirety, but this was not a common feature. In many instances, 'joint working'

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involved a sharing of responsibility, with both health and social services taking part in the care. Decisions about whether nursing or social need predominates remain contentious, even between colleagues.

> 'Yes, and I felt that if anybody was a nursing need she was... and then she came home that weekend and my colleague visited her...but she felt that she was a social need... so all we will do is monitor' (DN3, CaseL)

The 'etiquette' which Griffiths and Luker (1993) identified as (perhaps unhelpfully) existing within district nursing teams would presumably preclude an open disagreement between colleagues, but the shared responsibility allows a monitoring situation to continue. Indeed, data from all four cases suggested that collaboration between health and social services which recognizes exclusive lines of responsibility, was not sustainable in practice. St Helens Metropolitan Borough Council Personal Social Services Department (1992) showed that there are many problems at agency level in defining the differences between health and social need, with very few areas of need being the sole responsibility of health or social services. Although this was recognised as a problem by the Social Services Select Committee (1990), there has been no further direction from central government about the matter.

Practitioners in all cases experienced a degree of difficulty in obtaining suitable opportunities to learn first hand about complex, inter-agency needs assessment, but this did not prevent them from identifying other inter-disciplinary or team working activities and opportunities. Certainly the trend in multi-disciplinary working is to circumnavigate official guidelines which may be seen as impractical by using informal word of mouth agreements which are suited to local situations (Young, 1991). Collaboration across professions operated largely at the individual, informal level, despite lack of evidence of formal joint assessments. This might potentially lead to individual disciplines continuing to assess along a professional format with a focus on referral in cases which require elements of provision absolutely outside their own professional domain or sphere of responsibility, for example:

> 'I did have a problem a couple of weeks ago where this gentleman was coming home from hospital and was only given a couple of days, but he wanted to come home to die [. . .]. I rang social services and said look I need a chair and I need one now, and they said you can't have one, we haven't got one for four weeks. I thought well right, that's great - he's got three days, and he did last three days. But luckily, because I pleaded on the phone it's amazing what you can get; they got me one from occupational therapy and I got a reclining chair for him [. . .] more often than not you can get what you want, but it's the time it takes to arrive that is the problem'
>
> (DN1 Case M)

Referral and separate working with occasional liaison seems different from the spirit of joint assessment and working as contained in the NHS and Community Care Act. However, the emphasis on teamwork and cross agency collaboration suggests that a more optimistic scenario is beginning to develop, with genuine sharing of information at an informal level.

> 'we actually worked with social services doing joint assessments sort of interagency work with them on various different aspects and sort of certainly with speech therapists and orthoptists - I don't say I do joint assessments but we work jointly with perhaps and sort of assess what's best for that family and with ventures such as the children and family centre and family work services . . . . . we'll perhaps have an agreement as to what we are going to do and what role we are going to play and what specific work they are going to do.'
>
> (HV3 Case M)

Simply 'getting on together' within teams seemed important to most practitioners, but the extent of actual teamwork varied enormously even within cases. Quite often, the key issue appeared to be one of trust and respect between professionals. In case N, where a great deal of distress and mistrust remained between agencies as explained above, the issues appeared almost insoluble in practice, while in case P, the dissonance created by seeing the duplication might (hopefully) provoke a movement towards resolution.

> 'There's no collaboration between Social Services and Health. District nursing seems as if we're out on a limb, there's us and them and we're not working together. The principle's right, but reality is different.
>
> (DN4 Case N

> 'What we are doing here is replication and it's a waste of energy and time'
>
> (HV CaseP)

Interestingly, curricular documentation generally promoted interagency working and learning in all four cases, although course content was not sufficiently specific to determine how this was to be put into effect. In at least one instance it would appear to be limited to working within the primary health care team.

In gap 2, there was a suggestion that responsibilities were firmly controlled by expectations that practitioners and managers each held of the other. Paradoxically, there was also a feeling that, in many instances, the practitioners acted upon situations for which they unilaterally accepted a responsibility. This was most explicit in case M, but featured across the board, sometimes simply as 'getting on with the job' regardless of restrictions and difficulties. When referrals were made or received, responsibilities were conferred, either deliberately through negotiation or by whether or not the referral was accepted.

In order to offset the cumulative nature of consecutive gaps in the needs assessment spiral, there often appeared to be a 'trade-off' between specification and practice in both the practice and learning dimensions and across all four cases. In all the cases, practitioners spoke of balancing the requirement for structured assessment and profiling data with alternative or supplementary unstructured, informal mechanisms, according to professional judgement.

In education for needs assessment practitioners were, again, unanimous in attributing learning to sources beyond what was taught in college and specified in the curriculum. In particular, the role of the community practice teacher was seen as important for the less formal, but highly relevant, practice and experience-based learning that was imparted. Good clinical role models were seen as vital through taught practice, supervised practice and into professional development. These examples suggest that actually creating a 'gap' may be beneficial where adhering rigidly to specifications may, as seen above, amount to less than the desired outcome.

Indeed, in all four cases, the extreme importance and influence of the community practice teachers (CPT) was noted, whether this had been positive or negative.

> 'also we had a training when we looked at our care planning skills at the moment and that was excellent and that was run by the CPTs' (DN3 Case L)

> 'They [college] talked about theories and practice of counselling and communication but you need to physically go and do it and learn from experience'
>
> (DN2 Case P)

Several instances were cited in which a highly skilled CPT had helped students to understand issues which had been taught inadequately in college, and the kind of learning which was needed appeared to be dependent upon the skilful facilitation of learning in the practice field. The development of professional judgement involves integration of a wide range of skills, abilities, knowledge and ethical awareness, in order to bring them appropriately to bear upon their needs assessment practice. It is this integration which can only be learned through and in practice, where the multitude of issues described in each of the foregoing sections come together to create the complexity and variability which is the reality of practice. This will be considered in the next, final section.

11. REALITY OF NEEDS ASSESSMENT

The different ways of considering of needs assessment which were represented in the data have been set out in the preceding sections to provide a means of classifying the variants and help clarify the whole phenomenon. Taken together, the descriptions amount to a kind of 'taxonomy of needs assessment', as summarised in Figure 11.1. It is possible to describe each aspect and group separately in the abstract, but each element contained under the broad headings appears independent of the others, so any combination may arise in the practice situation.

Figure 11.1

Taxonomy of Needs Assessment

1 ideals	2 types	3 timing
• of policy • of nursing • ascribed worth	• purpose • formality, specificity • complexity	• client issues • service issues • practice issues

However, the clarity and apparent simplicity which is achievable in the abstract appears far more elusive in the reality of needs assessment, as the different elements cannot be readily separated when situated within individual people, families and communities. This may account for some of the gaps between the more abstract strategic and policy decisions (including curriculum planning), and the reality of what actually occurred as those policies were put into practice. Schön (1983) famously suggests that:

> There is a high hard ground where practitioners can make effective use of research-based theory and technique, and there is a swampy lowland where situations are confusing 'messes' incapable of technical solution. The difficulty is that the problems of the high ground, however great their technical interest, are often relatively unimportant to clients or to the larger society, while in the swamp are the problems of the greatest human concern. (Schön 1983: 42)

Perhaps there is a 'high hard ground' of policy and strategy as well as of theory and technique. Certainly the messy, variable and multifaceted nature of need was reflected in data across all four cases. So, too, the assessment practices described as necessary to cope with these features emerged as variable, hugely diverse and intimately bound up with the whole of community nursing work. The practitioners generally recognised the complexity of assessing the needs they encountered, perhaps acknowledging that their own perceptions and level of ability was one of the variables which helped to add to the confusing diversity:

> 'I always think of needs assessment as being, I know it's supposed to be individual but I always thought it would be more community where I am; because it is a very sort of individual thing. Each family's needs assessment is completely different and in the community we see so much need in S_____ it amazes me. I find it quite startling the more I look the more . . . . . God, there's just so much there. Needs assessment for families is very sort of different really. I think it's very different to each health visitor as well.'
> (HV1 CaseL)

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The multiplicity of potential combinations might account, too, for the apparently unpredictable manner in which many of the needs were presented, a point which was noted by the researchers in a large number of the observed visits. This was not an aspect which featured in the observation schedule, and it is hard to know how it could have been observed with any degree of reliability. However, the extent to which the type of assessment and associated needs could be accurately predicted before reaching the client's home appeared quite limited. In one area, for example, shortage of health visiting staff had led to the introduction of an 'emergency policy' specifying that only new birth visits should be carried out routinely - but other issues intruded:

> *In the car, the health visitor explained that this would be a primary (new birth) visit, geared towards assessment of a baby and post-natal mother whom she had not met before. She held no other children's records for this address, but the midwife's referral indicated that this was a second baby; there were no unusual features. Instructions about how to reach the isolated farmhouse were included, and two young lads were playing in the garden as we arrived. The health visitor opened the conversation by inviting the mother to say how she was, and to say if she wished to ask about anything. The mother had little to ask about the new baby, but quickly turned to her stepson's behaviour in school and at home. A brief question about hearing from the health visitor elicited the mother's concern that the child had suffered a spate of ear infections, but she did not know how to get his hearing tested. She talked through the various possibilites of his reactions to the new baby, or to the loss of his mother who had died four years earlier. With her own son, too, she was aware that he needed help to deal with the unresolved conflict surrounding her divorce and acrimonious access visits by his father. The visit lasted nearly an hour, focusing mainly on the needs of the two school-aged children, and concluded with the health visitor undertaking to arrange for the child to have his hearing tested and return to explore the other issues further.*
>
> (Observation - HV5 CaseM)

Thus, the reality of practice requires practitioners who are able to deal with unexpected eventualities when setting out to assess needs. Indeed, it has been suggested that within health visiting, it is only really possible to designate visits as 'routine' once they have taken place (Cowley 1995a). In this study, district nurses also faced unpredicted situations upon arrival at the home of various patients.

Theories of professional expertise generally aim to account for the knowledge needed to 'reframe the situation' (Schön 1983) or at least 'reset goals and priorities' (Eraut 1994) when unexpected or puzzling events arise in practice. The challenge for education is to prepare practitioners who, in the face of such complex and unpredictable situations, are able to identify the type of assessment required and to take this fully into account; who can draw on the skills required to elicit needs with regard to issues of timing, and demonstrate the application of appropriate ideals in practice. Furthermore, the 'gaps' which have been highlighted at each stage of the foregoing analysis are cumulative and apply within the provision of education and service provision.

GAP 4: PROVISION - PREPARATION - PRACTICE

The final gap is an amalgam of all the previous gaps as the spiral completes its circuit. Specifically, it measures the gap between student learning and its evidence in needs assessment practice, concurrently with the gap between service provision and its evidence as a basis for educational preparation. In other words, both dimensions cross the education-practice barrier, accumulating the gaps which arise between theory and practice, and between policy and practice. Thus, this last section is essentially about how service provision and education interact; the two dimensions often appear as mirror images of each other, as the multiple aspects described separately in chapters 8 to 10 all merge into one single point in the reality of practice. Four main aspects of the data illustrate this amalgamation; these concern

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first, the acquisition and use of knowledge of theoretical topics and service provision; second, learning in practice before and after qualification and third, issues relating to professional responsibility. Fourth and finally, this chapter will conclude with a brief consideration of the difficulty of evaluating the appropriateness of needs assessment practices, given the multi-faceted, inter-related and value-laden nature of the activity.

Knowledge in use

There are numerous theories about how professionals use knowledge in the practice setting. Schön (1983) distinguishes between the technical rationality of theory applied to practice, and the professional artistry which occurs when internalised, personal knowledge is used. Eraut (1994) reviews the various theories of how professional knowledge is used in practice, pointing out that this may be through replication, application, interpretation and association, while Carr (1995) suggests that critical theory offers a stronger explanation. There is, therefore, no simple model of 'applied knowledge', although there is an implicit need for learners to know how to utilise the underpinning theory and cope with the reality of practice.

Accordingly, the following report of how the practitioners appeared to use different aspects of a basic knowledge base is not intended to offer a robust or definitive statement. Nevertheless, at a simplistic level it was possible to observe the use of knowledge about child development, for example, when health visitors explained to parents why they were asking children to perform certain activities in their checks, or of pharmacology when district nurses explained medication they were dispensing to their patients. Observed knowledge use is summarised in Table 11.1; each observation could include more than one topic.

Table 11.1

Observed knowledge in use during visit

	Case L	Case M	Case N	Case P
number of visits observed	*20 DN 19 HV*	*7 DN 20 HV*	*15 DN 13 HV*	*20 DN 11 HV*
service provision	15 DN 13 HV	3 DN 11 HV	11 DN 6 HV	3 DN 7 HV
development	1 DN 15 HV	0 DN 15 HV	0 DN 8 HV	0 DN 10 HV
research	2 DN 3 HV	0 DN 6 HV	7 DN 4 HV	0 DN 1 HV
psychology	1 DN 0 HV	2 DN 2 HV	4 DN 5 HV	0 DN 0 HV
biology	3 DN 14 HV	7 DN 7 HV	15 DN 10 HV	9 DN 5 HV
ethics	1 DN 1 HV	1 DN 3 HV	7 DN 4 HV	0 DN 3 HV
pharmacology	10 DN 0 HV	2 DN 9 HV	7 DN 0 HV	8 DN 0 HV
sociology	5 DN 0 HV	0 DN 1 HV	0 DN 2 HV	0 DN 0 HV
political	3 DN 0 HV	0 DN 0 HV	0 DN 1 HV	0 DN 0 HV
pathology	16 DN 1 HV	2 DN 9 HV	8 DN 1 HV	10 DN 0 HV

At times, aspects of knowledge use could be discerned within the interviews, as well.

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> 'so it's up to me to keep up to date with the modern trends and for example, warmed normal saline, I mean I'm now always, if I'm irrigating a wound with normal saline I mean, the advice is to use warmed normal saline and I know the theory behind it so I do always warm it up first and often I've had a patient saying "Oh you needn't warm that up for me Nurse", thinking you know, I'm just doing it out of kindness.'
>
> (DN5 Case N)

There were inevitable difficulties in classification. This district nurse can relate her knowledge of wound healing to decisions in practice, which is the important thing, but it is debateable as to whether it is a knowledge of 'biology' (as signified by normal physiological processes of healing) or of 'pathology' given the presence of the wound in the first place. Even so, it was apparent that there were broad differences along fairly predictable lines, with the vast majority of instances of use of knowledge about bio-pathology being displayed by district nurses, while child development featured almost exclusively among the health visitors (the one exception being a district nurse involved in children's nursing). Furthermore, the breadth of basic knowledge required and the diversity of the roots from which it is derived adds to the weight of evidence of the complexity of learning about needs assessment.

Several of the practitioners acknowledged that it was not until they had built up a repertoire of experience that some of their theoretical learning began to make sense. The issue of gaining support while developing confidence in developing their expertise in reaching assessments will be considered further below. The need for personal experience in an area was, perhaps, never clearer than in relation to finding out about other services to which assessed clients might be referred.

> 'Like for example, we have a women's refuge in the area, and until a mother or a woman says to you, I need to get out, where can I go - I mean, until you need to deal with that situation I don't think you retain that knowledge until you've been through it, but you need to know it's there. And I don't think in saying to a client I do know of this refuge, I'm not sure what you do, but I'll go and find out and get back to you as soon as I can - and I think that's important in accepting your limitations really, and being honest with the client and not pretending that you know all about it because if they then go and find what you said is a load of rubbish then they just lose all confidence they had in you.'
>
> (HV4 Case M)

The NHS and Community Care Act suggests that assessments are supposed to be made without reference to existing service provision to avoid the temptation to fit needs to services instead of the other way around. However, as this excerpt illustrates, it does seem important at times for practitioners to have information about service provision to impart to clients while assessing their needs; this is linked to the ability to refer them on. As Luker and Chalmers (1989) indicate, referral may involve a lengthy period of negotiation, involving processes which they designated 'working up the referral' for both the client and the receiving service; this can only be carried out with knowledge about what is available. Information-giving about services was often observed to be a fairly informal suggestion or comment, perhaps just stating that a particular service exists; this might be the first step towards preparing people for a possible referral, giving them time to think about it in order to enquire further at a later date, as described by Luker and Chalmers (1989). (Table 11.2)

Table 11.2

Information giving

	Case L	Case M	Case N	Case P
number of visits observed	*39*	*27*	*28*	*31*
NHS service provision	31	16	23	15
other services	9	9	10	7
about need/condition	33	19	26	22
access other professionals	16	8	13	3
access other services	11	5	10	3
other professionals involved in care	11	12	17	12

Information was not only given about formal NHS and social service service provision, but included a wide range of informal, voluntary and commercial or private agencies as well. For mothers and young families, this might incorporate services such as playgroups, nursery services, post-natal groups and ante-natal classes run by voluntary organisations, while older clients were advised of residential or nursing home care, meals and cleaning services, and various charity-funded services for respite or care. The idea of the 'mixed economy of care' appears to be well established, often giving rise to an apparent maze of services, and people may need some guidance as to whether it is appropriate given their particular needs. As in primary health care provision, many of these services operate self-referral systems, although some involve direct cost to the client and some have specific criteria for entry, so 'information giving' involves separate details about eligibility, and how to access them. This may involve the practitioner in explaining the operation of local policies; in turn, this may involve some ethical dilemmas:

> 'that's quite an ethical issue [. .] I just apologise and say I'm sorry there is no playgroup subsidy [. .] just seeing people who are obviously in need but there aren't the resources there to fulfil that need'. (HV2 Case P)

> ' . . . difference between need and want is about constraints on what people get. Some people ask for things which seem unnecessary and yes you've got to say "I don't think it's wanted" I mean bathing is a most common one. There are differences also between whether it's warranted or not available It can be both' (DN6 Case N)

The data suggested that developing an ability to use the different services to gain the appropriate care for their clients was an important part of needs assessment. Many of the practitioners remained confused about the proposed division between assessment and provision of services, which did not accord with their everyday experience or seem to serve a useful purpose, in the way that knowing 'who to go to' could help solve a client's problem:

> 'It doesn't necessarily mean I can sort it out [. .] if there's a need I should know where to go or who to ask for help. I always know who I could ask. I don't understand how you can always separate provision and assessment [. .] because I assess and I provide. It's more time efficient' (DN4 Case P)

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Importantly, students need to acquire knowledge in a way that enables flexibility and adaptability when they come to use it in practice. Furthermore, finding out about local services and the way other agencies worked was bound up with practice experience, which was where most of the learning about needs assessment seems to take place.

Learning in practice

As suggested above, in the reality of practice, students and neophyte practitioners come face-to-face with the whole spectrum conflicts of interest, policy and resource constraints, ethical dilemmas and problematic interagency relations. Preparation needs to encompass a wide variety of skills in determining how to respond to such variability. This was not always apparent, although it was in the practice situation that a wide repertoire of nursing and health visiting skills and theories, including an ability to respond to intuition and to changing circumstances, could be integrated into a meaningful experience.

> 'I think most of the preparation came from the practical side of the training rather than the theoretical side, came from actually being in the community and working with your CPT and on your supervised practice rather than input from the University. But on saying that, I think it would be very difficult to do a session say in the University on the Community Care and realise how much you would retain unless you actually were involved in doing it in the community.' (HV4 Case M)

> '. . . we had a training when we looked at our care planning skills at the moment and that was excellent and that was run by the CPTs.' (DN3 Case L)

Several students had experienced poor teaching in the practice field, but on the whole, the community practice teachers (CPTs) enjoyed their confidence to a much greater degree than the college lecturers, who were often perceived as out of touch with what was actually happening in the field. The comment made by this health visitor is, perhaps, demonstrating an emerging awareness of the gaps between policy intentions and practice which she suspects is not recognised by the lecturer:

> 'because I think the people teaching hadn't been out in the Community for a long time, that has disadvantages. Um, and they tended to take everything that came from the NHS Management Executive and supervision [. . .] it was a bit sceptical.'
> (HV2 Case N)

However, in each case there were at least some lectures which were singled out for high praise; often this was by a subject specialist.

> Yes, we had very excellent social policy lectures. Er, I think there is a great deal of difference between being taught by someone who is a specialist in their area but I think that there the students feel much more secure because you've got the access to their knowledge basically (HV2 Case N)

Once qualified, the extent of support and opportunities to consolidate learning undertaken on the course varied markedly. As highlighted in chapters 5 and 6, a number of newly qualified practitioners had great difficulty in finding work on the appropriate grade in the first place. This was especially marked for the district nurses, although a number of health visitors also experienced a long period of uncertain employment or part-time, temporary contracts immediately after obtaining their qualification.

Understandably, this tended to diminish their confidence and, in purely practical terms, prevented them from building a repertoire of experience from which to develop their practical expertise, a process which seemed barely complete by the time the course had finished. In view of this, the period of supervised practice at the end of the course, as highlighted here, seemed critical in at least allowing a relatively protected period, and ensuring that the student was afforded the opportunity to put into practice some of the learning gained earlier in the course.

> 'You certainly need the course, you certainly need that supervised practice - I was a nervous wreck that three months [. . . . .] those three months you are the responsible person who is going in to decide when to do the dressing, how many times a week you're going to go in, what treatments to use. That is frightening . . . but I had a brilliant team and if I had a problem I would just come back and say, do you think this is right, and they would say yes, or why don't you try such and such a thing. They were very good, because I had a terrible supervisor'
>
> (DN1 Case M)

It is worth noting at this point that, since these data were collected, the new regulations for community nurse education have been implemented (UKCC 1994), which reduce both the total length of the programme, and the period of time for learning in practice, and remove the formal requirement for students to complete this period of supervised practice.

There is an existing recommendation that all newly qualified practitioners should benefit from a period of preceptorship (UKCC 1991), but this remains at the discretion of the employer; the data from this study was not encouraging in this regard. A few did report having formally arranged preceptorship periods, although they seemed to be in the minority, and they were not universally supportive even if arrangements were in place. Overall, there seemed to be a huge variability in the amount of support which was extended to the new practitioners when they qualified. It was often informal and appeared to depend mainly on the goodwill of colleagues and circumstance of the base from which the neophyte practiced; in some cases it appeared invaluable, but in others, pressure from colleagues to conform to existing practice patterns served as another hurdle for the new practitioner to overcome.

> 'fortunately Dierdre who I share an office with and I work very well together, she's obviously a lot more experienced as a health visitor than I am and I find this very helpful. (HV2 Case N)

> 'the hardest thing is persuading team colleagues who have not done any academic work who don't see need important relevance or the relationship of a community profile to their day to day work or its influences on the patient and the family' (DN 5 Case N)

In several of the more poorly staffed situations, the newly qualified practitioner had no immediate peers of the same discipline at the base from which she worked; while contact by telephone was always possible, this did not afford the same level of support as when sharing an office. As highlighted in chapter 9, attachment into primary health care teams is increasing and management heirarchies are becoming flatter. It seems very likely, therefore, that the extent of immediately available support for newly qualified practitioners will decrease in future, so the amount of responsibility shouldered by the neophyte seems likely to increase proportionately.

Professional Responsibility

The notion of 'profession' was once characterised by a relationship in which the professional would be considered directly accountable to her or his clients. It is questionable whether such a situation has ever applied in nursing, but certainly these formal accountability patterns are changing among professionals in general, so that Eraut (1994) now refers to the 'moral accountabilities' of professionals at work. He lists accountability to other workers, the team or department and employing organisation on one hand, and a long list of 'external stakeholders' which includes individual actual and potential users and communities on the other. Further, Andrews (1995) lists four constituents to whom nurses may be required to account for their actions; through criminal courts (if a law is broken) or civil law (if a client sues for negligence); employers may take disciplinary action and finally the profession may apply sanctions deemed appropriate through its regulating body, the UKCC.

The notion of accountability to clients still holds a particularly emotive sway, with a number of qualitative studies revealing that community nurses are likely to 'feel responsible' for helping clients in a way that may extend the formal requirements of their employment contracts , if that is deemed necessary (Appleton 1996b, Cowley 1991a, de la Cuesta 1993). As outlined above, if restrictive protocols or service specifications appeared likely to inhibit the delivery of what seemed necessary care, many practitioners in this study appeared to simply 'get on with the job' of providing whatever they believe is required. In a few cases, the practitioners seemed able to extend this sense of responsibility, accepting a duty to influence the organisational structure, perhaps by feeding information into the contracting round or setting out to develop services which seemed to be needed but which were currently absent.

> 'I have approached people within social services with certain ideas about groups we could set up..I approached a youth development officer and we invited some school nurses and an educational adviser to come along to our meeting'
>
> (HV1 Case P)

This is termed 'professional responsibility' here, since it does seem to lie slightly outside the formal structure of 'professional accountability'. It is closely linked to autonomy, and refers to the confidence and capacity of the practitioner to be prepared to take on a duty, activity or additional skill on her own cognisance, without reference to another person or higher authority. Of course, such independence may be explicitly prohibited, or discouraged by either the disempowering impact of an uncertain employment situation or the exhaustion of unreasonably heavy caseload responsibilities:

> Yes, they do have a standard setting group. I'd like - I'd actually offered at one of the meetings, I actually said 'could I' but I'd only been here three months. But I would like to get involved a lot. (HV1 CaseL)

> 'I don't think people [staff] have any choice in the matter, it's a case of having to accept it, but also I think, they are not really encouraged to question about the new changes or their introduction . . . . if you actually question something and it stops it going ahead, you know, you then learn more about it, and it's a fear that your going to be (*inaudable whisper*). I think in today's climate you're perhaps even more conscious of upsetting the applecart, which is a big concern so people won't - they're either not giving their true opinion so they let something be implemented when they don't really agree with it, and I think when that's actually implemented and it affects practice, then professionally they're not going to have the same enthusiasm and motivation to carry that through' (DN1 Case M)

Equally, however, given the flattening of management heirarchies within community trusts discussed above and in Chapter 9, it seems likely that there will be an increased need for newly qualified pracitioners to be capable of acting with a higher degree of independence in the future. There does seem to be an educational need here, to enable students to develop the extent of their self-reliance and confidence in a way which reflects a deep ethical awareness of their multiple accountabilities to employers, to clients and to other stakeholders.

In some cases, for example, there remained an expectation that 'someone else' should come up with an answer - this district nurse, for example, described how keen she considered she and her colleagues were to embrace new ways of working, although she implied that she was too busy to update her research knowledge during her working week. She did not feel that this was a problem which she should be expected to address; in her view, that responsibility lay elsewhere:

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DN when ever we have a 'rep.' who comes with the research, that's really the only time we ever hear anything. [. . .] and it just seems like everybody's waiting.

Int: So you think research should be brought to you.

DN: Yes, or an opportunity made for us to get to it. [. . .] I mean I've heard it so often that, you know its very easy to push it onto the individual, but that isn't the answer. (DN3 Case L)

However, other practitioners semed to develop an awareness that it was, in a very real sense 'up to them' to discover for themselves whatever it was that they needed to know, instead of waiting for others to take the lead.

> 'Then sometimes it's just a case of picking up the 'phone and trying to find out what the service is and where I can get it from. I still go away and start finding about mattresses and alternatives' (DN3 CaseP)

> 'We are the family health visitors, so really you know, we are there to health visit in an area so you will obviously take the opportunity to do whatever work you can. . . I don't know if it's in the Patient's Charter or whatever, but I think it is part of our responsibility as health visitors to provide that sort of service'
> (HV3 Case M)

> 'My CPT was very good at helping me out afterwards when we debriefed she was very good at pointing out those needs were identified and I felt I worked in a similar way to her really. I mean, she was helpful in that, but in my supervised practice there wasn't a lot of input really about that so it was up to me . . . '
> (HV2 Case M)

It was particularly noticeable among most (but not all) the health visitors in Case M, whose syllabus included a module which explicitly set out to develop this sense of responsibility in a way which would persist and develop after the end of the course. The 'Reflective Chronicle' is described in the documentation as a course which draws heavily on experiential learning, group discussion and peer evaluation of reflections in college, of experience gained in practice. Citing the perceived importance of 'praxis', the module claims to be 'specifically designed to lay the foundation for the acquisition of 'professional artistry' (Schön 1987) with respect to health visiting once the student has gained sufficient experience as a practitioner.'

The subjective and evaluative nature of the idea of 'taking responsibility' precludes any comparison with the other cases, but the issue demonstrates the inseparable influences of the actualised ideals of education into teaching and learning, with those of service into planned provision and practice. Just as 'needs' appear inseparable from the highly complex client situations in which they are found, so the ability to 'assess needs' is profoundly bound up with the particular context of an individual practitioner within her working situation. Likewise, it can be problematic to reach reliable evaluations of the appropriateness of actions taken to assess needs, which will be explored in concluding this cross case analysis.

Evaluating the quality of needs assessment practice

In considering how to evaluate the quality of needs assessment, three fundamental issues have been singled out as potentially contributing to the opening or closure of 'gaps' in the spiral of policy, planning and provision. The multiple, sometimes conflicting agendas associated with conceptualising what is meant by 'need', and whose perception of this counts in assessing which services will be offered were explored; it was suggested that this can only be evaluated through an empirical decision about what is appropriate within a particular context and setting. Importance was attached to incorporating the consumer view at all stages of the spiral, beginning with the way national policy is set, through to the planning of local

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provision and eventually into the delivery of a service which is deemed to be individually appropriate; notions of participation and partnership are central to this theme. Likewise, to maximise quality of the service delivered, the extent of interdisciplinary and interagency working was explored through the data, as the way national policy is translated into local service agreements, and the impact these have on needs assessment practice within community nursing.

Overall, given the multitude of possibilities which exist within needs assessment practice, it seems apparent that any evaluation of the quality must incorporate some acknowledgement of whether the approach used is appropriate to the situation. This presents a particular problem for the educators of community nursing students whose students all enter their courses of preparation with a first level nursing qualification, and are therefore already deemed competent at assessing the nursing needs of individuals who are sick or well. The challenge for community nurse educationalists is to establish a way of determining whether the needs assessment practice of these students is sufficient for them to gain a further qualification, which has been designated as 'specialist level' under the new regulations (UKCC 1994).

Throughout the data collection and analysis, the research team have debated and discussed the multiple and often conflicting interpretations which could be placed on separate aspects of needs assessment. It became extremely difficult to disentangle perceptions of 'good (or poor) community nursing practice' from 'good (or poor) needs assessment practice'. Observations alone were completely inadequate, but in conjunction with the interview and information given informally by the practitioners during the observation period, it became possible to reach some tentative opinions about the quality of the practice.

Two case examples, compiled from the observation and field notes of different researchers, are offered in conclusion, not as a solution, but to illustrate two key issues which have been asserted at various points of the analysis. The first is the contention of most of the practitioners that needs assessment is a continuing process, which often cannot be completed within a single visit. The second is that needs assessment is deeply embedded with the rest of community nursing practice, with the whole of service provision and with the perceptions of need held by consumers and the community being served.

This phase of the study collected data from a very singular perspective - that of the neophyte practitioner - without formal input from consumers or from purchasers or providers of community services. While this is undoubtedly a limitation, it is also the only perspective which is open to scrutiny and direct influence by educationalists as they prepare each new generation of new students. The analysis has attempted to demonstrate how it is possible to view the wider issues associated with needs assessment through this single channel. The final phase of the study is concerned with taking educational recommendations which arose from the insights gleaned from this analysis back to a wider audience.

Case Example 1: DN2 Case L.

"Betty"* was originally an enrolled nurse who had done a RN conversion course, before going on to study district nursing. She had varied hospital experience which extended to ward management level. She described her personal background as working class, and she had lived near to her practice area for most of her life. She was a person who appeared to concentrate on practical solutions to everyday problems, wherever possible.

At the beginning of the day, she appeared quite open, although a little anxious. At the clinic she was reserved with other staff and appeared to be a peripheral member of the team of qualified community nurses. Her main point of contact was with those of lower status and qualifications.

During observation, the researcher saw several contradictions in her behaviour which were notable. Although Betty appeared to have a good relationship with her clients, her manner of communication was brusque, combative, and often blunt. She used teasing, cajoling and joking to exchange information with her clients, and they communicated in the same manner, often with rebuttals or sarcasm. The researcher was aware that what is deemed "good" communication practice in nursing was different to what she observed between Betty and her patients. However, the researcher believed that this partly demonstrated a cultural difference in patterns of communication between those observed, and the nursing profession's dominant ideology.

Betty engaged in poor hygiene practice, demonstrated by exposing patients to cross infection, either from one leg ulcer to another for the same patient, or by omitting to clean hands between patients. However, in the interview Betty demonstrated that she knew about the risks of cross infection when she discussed the subjective nature of need by giving examples of value judgements about patient hygiene practice.

Betty showed a great deal of cognitive dissonance about what she was taught at college. She was given assertiveness training, but felt unable to use these skills in practice, especially with the primary health care team. She was taught to make independent professional judgements about client care, but gave some examples where these were over ruled by other district nursing sisters or management. Betty understood the rationale underlying a separation of health and social care, but could not integrate it with her own view of nursing, including what she had learned at college whilst a district nursing student. Betty used her knowledge to try to understand her clients and generally liked them, but where disagreements occured between them about definitions of need or types of care, she felt unable to explore avenues which might lead to resolution of their differences; instead she adopted a "stand off" position.

At the end of the interview, Betty expressed a sense of alienation towards her managers, her colleagues, and to a lesser extent the district nursing course. The mediating factor which she claimed had "redeemed" her specialist education was the personal contact and supervision offered to her during practice by the district nursing lecturer, who in the examples given had shown Betty great sensitivity and cultural understanding. Betty had poor CPT supervision during training, and no mentorship after qualifying.

Education for district nursing had offered Betty some positive things, but clearly left her many unresolved difficulties. Although Betty was white and English, she came from a "grass roots" working class background which was very different to the majority of nurses or colleagues. Her education and work environment appeared to be culturally alien to her, and she expressed many examples of a lack in confidence in herself which were related to this. This appears to demonstrate the cultural sensitivity required in both needs assessment and education, but also the difficulties that can arise in the practice setting where practitioners are unable to integrate experiential learning and theory in their practice. It also shows how factors such as culture can militate against a practitioner becoming self-directing and addressing their continuing education needs.

*Not her real name

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Case Example 2: HV5 Case M

In the car, Vera* (the health visitor) explained that this visit had been arranged during a telephone call yesterday from the mother of a one year old who was not eating. At the surgery this morning, she had discovered that the child had since developed a virus, and had been seen as an emergency by the GP. However, she still regarded this as a priority visit, in view of the family background. The caseload had been 'vacant' for several months prior to her appointment, and this mother's severe post-natal depression had gone undetected for six months. In a series of visits, Vera had used the Edinburgh Post-Natal Depression Scale to help the woman express her feelings, and accept help; she was given a course of Prozac and the community psychiatric nurse had been involved for a time.
(NB team/consultation: referral/collaboration: use of structured assessment scales)

The child had been very understimulated during this period, and his development remained slightly slow, which needed watching. The mother was reported as recovering quite well mentally; she remained marginally agarophobic, finding it difficult to get out very far. Vera commented on the lack of facilities for young families in this area; it was a fairly new housing development and not a lot had been developed yet. Health visitors were involved with community development work on the more deprived side of town, but there was no formal provision here which made it extremely difficult for women who were slightly vulnerable like this. Although she was recovering mentally, there were also concerns about the woman's physical health; a cervical smear had shown an abnormality which required laser treatment, and she was losing weight at quite a significant rate - following discussions, the GP was trying to arrange urgent further investigations at the hospital.
(NB family and community awareness: teamwork/collaboration)

The family lived in a ground floor flat, and just as the thin and frail-looking young woman opened the door, Vera pointed to the doormat, where lay the carcase of a dead mouse. The child's father was leaving as we arrived, and Vera spoke with him briefly, enquiring about his holiday arrangements, acknowledging how stressful the last few months had been for him. After that, she engaged the mother in conversation, beginning with how the child had been since seeing the GP. She accepted the mother's assertion that he was no better, and her anxiety about him not eating, but suggested offering lots of fluids and said she would arrange to weigh the child once he had recovered, to be sure that he regained any weight he lost.
(NB family awareness: accepting client's view of need: knowledge of child development, pathology)

The child was just beginning to toddle around, which was a new development since Vera had last seen him; she remarked on how he would soon be 'into everything' inviting further comment from the mother; the conversation moved towards safety and the need for a fireguard and the stone steps to the small garden - Vera almost appeared to be congratulating the mother for having thought of it already, rather than advising her about any specific action.
(NB Timing: future planning. Is this 'intuitive' assessment? no formal structure was used, and the assessment and provision of service - if this 'advice' qualifies as such - were hardly distinguishable as separate even to the observer who was present)

Next, Vera enquired about the mother's health; she said she had fallen yesterday and injured her back which was now painful, and she was still concerned about her weight loss. Vera showed her how to lift the child without straining her back further and discussed her forthcoming investigations in a little more detail, enquiring what she had eaten yesterday and what she was planning for lunch today. As she talked to the mother, Vera simultaneously played with the child, watching him walk and engaging in the monosyllabic conversation of a one-year old, and continually referred the conversation back to the mother to take the lead. When the mother had exhausted her questions, Vera prepared to leave, asking casually whether the family had a cat? The woman looked surprised at the question, and appeared mildly amused to hear of the dead mouse on her doormat - perhaps it had come from the building site along the road, or perhaps the neighbours had a cat. She would leave it for her husband to deal with, she said, as we left some 20 minutes after arriving.
(NB partnership, sensitivity and timing issues: some very precise information gained about food intake, and mental and physical health implications of possible pest infestation considered)

*not her real name

PHASE III

12. CONSULTING THE EXPERT GROUP

The third phase of the study was designed to ensure that preliminary findings and associated preliminary recommendations were subject to scrutiny by people working to improve needs assessment and quality of care; in education, research and in practice.

Method

This phase of the study took place in March 1996, and consisted of consultation of an expert panel, approved by the steering group to the project. The names and addresses of members of the expert group can be found in Appendix 7, but their comments have been anonymised to ensure confidentiality. They were chosen to represent a varied constituency: purchasers, providers, policy analysts, experts in needs assessment and quality assurance, and health visiting and district nursing educationists / researchers. Initially, the panel consisted of 11 members, but no response was received from two, so the final number was 9.

A working paper was written which contained an overview of the study: its methods, modes of analysis, the findings from phase II and initial recommendations for consideration. This formed the basis for the final report as shown here, although greater detail about methods, research aims and analytic strategies have been included here which were not in the working paper. The working paper was mailed to the panel, who were given 3 weeks to return their comments.

The panel was asked to consider the feasibility and utility of the recommendations which are summarised in Figures 12.1. The responses from the expert group were subjected to a content analysis which has ben collated in Figures 12.2 to 12.7. The overall results are summarised below.

Findings.

The comments from our expert group ranged from a paragraph about the study, to three pages of detailed comment. They can be summarised as follows.

The experts felt that it was right to draw attention to the fundamental role of needs assessment in the practice of community nursing, and believed that it should form a vital part of the curriculum on specialist community nursing courses.

The experts believed that students should be able to understand the different ideals which underpin assessments, both in policy and in practice. They were concerned that education in specialist community nursing courses should examine the ideals of policy and holism, but also allow enough time to develop an adequate understanding of the contracting process, service requirements and the need to ration health care. Although they recognised that students often found it difficult to achieve an understanding of the different ideals which underpin needs assessment, the experts were concerned that district nurses and health visitors would be in an 'impossible position' if educators failed to address the reality of these aspects of clinical practice.

Several experts commented on the complexity of the task facing district nursing and health visiting lecturers attempting to address these issues. One reason for this might be the difficulty in identifying ideals which consistently run through policy documents. Another related reason may be the clear gap between the rhetoric of policy and the reality of practice. One expert commented that clinicians are not always interested or receptive to information about the wider context of the NHS, and this could be a further barrier to educationists trying to teach about assessment practice. Another expert believed that lecturers would have to search for, and develop, more appropriate models of assessment and care than offered by the existing

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nursing literature, but cautioned against the use of highly structured assessment formats.

Figure 12.1: INITIAL RECOMMENDATIONS FOR EDUCATION

1 Needs assessment skills appear central to all community nursing, so their acquisition is intimately linked to the development of specialist community health care nursing skills.

2 Notwithstanding this, the particular skills and knowledge required for needs assessment (especially for formal and structured assessments) require highlighting, to aid clarity and the learning process. It is important that students understand the different ideals which underpin needs assessment according to their basis in holistic nursing or policy-driven perspectives, as well as understanding the various types, and the way the timing of assessments varies according to different clients', practice and service requirements.

3 The principles of needs assessment should be taught as part of the common core between all community nursees, and some aspects of this learning might beneficially be shared with students from other disciplines, such as trainee general practitioners and student social workers. However, there remains a particular base of knowledge to underpin assessments made within the different areas of community nursing practice, and extra attention should be given to these within the specialist modules.

4 Developing the high-level skills required for the full spectrum of needs assessment should be centred around developing skills of professional judgement. This requires:

- the development of critical skills, ability to conceptualise and articulate practice. Education should continue to be minimally at level three (degree level) and consideration should be given to extending opportunities for post-graduate qualifying courses.
- the opportunity to acquire a sufficiently wide repertoire of experience in different needs assessment situations. Both the length of time spent in the practice situation, and the quality and range of experience available should be the subject of serious consideration by educational consortia.
- Central to the quality of learning through practice is the opportunity to observe an expert role model and teacher in a variety of learning situations, who should subsequently be able to reflectively discuss, coach and debrief the student following her own practice in needs assessment. Given the centrality of this teaching role, the level of preparation for community practice teachers may need to be upgraded.

5 Specific time should be given within the educational programme to enabling students to develop the emotional and personal maturity to accept professional responsibility for helping to influence factors which have an impact on their practice, as well to continuing to develop their own knowledge base in relation to new developments

Clinical research was seen as an activity which could improve a teacher's ability to promote students' understanding about fast changing areas of practice. The need for educationists to address their own continuing education needs was also highlighted.

The experts widely supported the notion that learning about assessment could be shared across professions and disciplines, some implying that this form of education would help develop joint assessment practice. However, one expert was concerned that specialist modules also addressed the detailed aspects of needs assessment for each community nursing specialism, which may help to address the problems students are currently having in overcoming the gaps in putting needs assessment into practice. The joint nature of needs assessment was stressed by two experts, who felt it had been given inadequate emphasis in the report. The danger of promoting a profession, rather than promoting health, was seen by two experts to be a possibility when considering the issue of needs assessment. One method for addressing this issue was suggested in which students engage in a critical appraisal of their own professional frameworks and values, and also those of social work and professions allied to medicine, relating them to assessment practice.

The importance of lecturers being well informed about practice in their specialism was again highlighted, although practical constraints to achieving this were acknowledged. One expert believed that the expertise of lecturers was an area which needed further elucidation in the study recommendations.

There was extremely strong support for the recommendations which related the skills of needs assessment to the development of professional judgement, not least because of the difference between the ideals and reality of professional practice. One expert pointed out that education to stimulate critical thinking in students was an extremely complex task, and a more detailed description was requested.

Experts were keen to emphasise the importance of learning through practice in educational programmes. There was some concern that appropriate role models were difficult to identify in the practice setting. Indeed, one panel member cast doubt on the existence of truly expert practitioners because of the rapidly changing face of community care. Another panel member pointed out that there was a need for education and development of the current workforce, especially in the area of needs assessment. The doubts about the quality of the learning environment in practice, and the difficulty of facilitating and monitoring students, led one expert to suggest that 'proxy' experience (such as the use of videos) may be helpful adjuncts to learning in practice. A suggestion was made that the difference between professional and user views about quality of life and service objectives might be another useful area of focus for study about needs assessment.

The need for education of CPTs at a higher level was acknowledged, with one expert recommending that this should be at Master's level. The resource implications for Trusts who are involved in the education of community nurses, particularly with respect to CPT provision, was something one panel member raised, and this could also be a barrier to achieving better education of students through practice in the future.

The development of emotional and personal maturity in students was recognised by panel members, but some experts questioned whether this was a feasible goal for educationists. One expert cast doubt on whether this can be developed independently, or is the result of, a student confronting difficult situations. The link between personal and emotional maturity and the development of ethical understanding was raised, and was believed to be an important area which education for community nursing could address. One expert pointed out that if the need for maturity was accepted, then there should be a specified gap between first level registration and specialised study.

Figure 12.2

Recommendation 1. *Needs assessment skills appear central to all community nursing, so their acquisition is intimately linked to the development of specialist community health care nursing skills.*

Expert 1:
No comment.
Expert 2:
No comment.
Expert 3:
Research team are right to highlight fundamental role of needs assessment to the practice of community health care nursing (CHCN) and specialist nature of education for CHCN. However, the findings also highlight the need for continuing education for CHCN lecturers, who may not currently possess appropriate knowledge or clinical expertise in the area.
Expert 4:
I agree.
Expert 5:
This is a statement rather than a recommendation which indicates that curriculum must include needs assessment skills.
Expert 6:
No comment.
Expert 7:
No comment.
Expert 8.
No comment.
Expert 9.
No comment.

Figure 12.3

Recommendation 2.*The particular skills and knowledge required for needs assessment (especially for formal and structured assessments) require highlighting separately , to aid clarity and the learning process.*

Expert 1:
No comment.

Expert 2:
No comment.

Expert 3:
Appropriate recommendation, which again highlights the need for continuing education for lecturers. Highlights the importance of lecturers being involved in clinically based research, so that teaching facilitates students' learning.

Expert 4:
I agree, especially about the need to understand the different ideals which underpin needs assessment. In my experience students often find this difficult, especially policy and resource driven needs assessment that permits rationalisation.

Expert 5:
Feasible. Needs teachers to be skilled in linking ideals, service and needs assessment. Differences in role between DN and HV seems to be the difference of the context of practice, whereas knowledge identified in this paper shows similarities between professions. "This paper adds insight into the links between needs assessment and policy context and this is a very important addition to community nursing education that has not been made so explicit before. This aspect ...will be more difficult to implement, but has to be addressed."

Expert 6:
"Trying to ensure that clinicians understand the wider environment in which they work is an uphill battle....Many staff seem almost unwilling to understand the wider context of the NHS, often claiming that it has little relevance to their work."

Health needs assessment has increasingly been regarded as the role of purchasers as the NHs reforms have established themselves. "I believe that there is enormous scope for this work to be done in an integrated fashion between purchasers and providers, particularly in primary health care."

Expert 7:
Agrees that wider context of needs assessment must form part of educational package, and argues that existing nursing models and structured assessments are inadequate in establishing objectives for client care. Need for a thorough consideration of cultural, ethnic etc. diversity and implications for assessment practice.

The notion that there are ideals in policy is questionable (Henwood,1992). It is important that students understand the policy making context and subsequent legislation, but equally vital that they are able to appreciate the nebulous nature of much of this policy rhetoric.

Expert 8:
Practitioners are in danger of being placed in impossible position if nursing does not recognise that CHCNs have to deal with employers expectations.

Practitioners must be educated so that they are not encouraged to be moral arbiters of clients' behaviours in their assessment practice.

Expert 9:
"There should be some clear guidelines on course content on the theory of needs assessment so tha the variability between colleges in diminished". Questions arise about what further studies are necessary for community nurses and when they should be done.

Expectations of policy are constantly changing in the upward direction, & medical, social services and nurses can never fully satisfy them. The problem for nurses is how to explain this to patients without leaving them too unhappy. These skills need to be included in courses.

Figure 12.4

Recommendation 3. *The principles of needs assessment should be taught as part of the common core between all community nursees, and some aspects of this learning might beneficially be shared with students from other disciplines.*

Expert 1:
No comment.

Expert 2:
No comment.

Expert 3:
Appropriate recommendation, highlighting the importance of lecturers with specialist skills undertaking the teaching of specialist skill (i.e. needs assessment) to CHCNs. Different emphasis on prevention for different community practitioners supports the notion of specialist modules, particularly primary prevention.

Expert 4:
"I strongly agree that needs assessment learning should be shared". From the commissioning point of view the starting point is always the population. Needs assessment could be carried out by any professional group, and is not the prerogative of nurses alone. Professional promotion should not be placed above health promotion.

Expert 5:
Seems fairly straightforward as long as the teachers in college are aware of the difficulties that students are having overcoming the gaps. Teachers knowledge base needs to be broad and up to date in order to give examples from practice.The links between policy and practice take time to access, and this is not an easy task for teachers on a everyday basis.

Expert 6:
Educating and developing clinicians together is a key strategic objective for this Trust. We believe that there are elements of both undergraduate and post graduate training which should involve all the professions...This would undoubtedly help with the needs assessment issue."

Expert 7:
Educationists should encourage students to engage in critical appraisal of their own professional frameworks and values, and also those of social work and professions allied to medicine, relating them to assessment practice.

Expert 8:
Joint nature of needs assessment is inadequately acknowledged in the conclusions of this study

Expert 9:
Joint teaching may reduce the possibilities of misunderstandings between professions, but cultural differences are far too wide to expect education to solve all difficulties

Figure 12.5

Recommendation 4. *Developing the high-level skills required for the full spectrum of needs assessment should be centred around developing skills of professional judgement.*

4a Education should continue to be minimally at level three (degree level) and consideration should be given to extending opportunities for post-graduate qualifying courses.

4b The opportunity to acquire a sufficiently wide repertoire of experience in different needs assessment situations. The length of time spent in the practice situation, and the quality and range of experience need considering.

4c Given the centrality of the role, the level of preparation for community practice teachers may need to be upgraded

Expert 1:
No comment.
Expert 2:
Although needs assessment at community level is a desirable part of community nursing, if CNs are educated to think that this is a regular occurrence in practice, they will experience problems in dealing with workload demands and relations with their immediate nurse managers. There is also a need for education for nurse managers for dealing with discrepancies between assessed needs and needs identified in contracts. Critical debates about the effect of policy on practice can only occur if educators have access to practically derived knowledge.
Expert 3:
"The relationship between the development of expertise in needs assessment and professional judgement cannot be emphasised too greatly.
Elaborate recommendation 4a further, particularly regarding the type of educational preparation. The development of critical skills in students may need more description than simply in terms of levels.
Recommendation 4b correctly highlights the importance of learning through professional practice and the important role of the CPT, as well as the need for sufficient time in clinical area. This highlights the importance of CPT preparation, and I would suggest that CPT preparation should be at masters level.
Expert 4:
Agree. On 4b include commissioning situations.
Expert 5:
4a and 4b are extremely important.
Expert 6:
Agree that degree level education is needed to develop the high level skills required for needs assessment, but suspect that there would be differing opinions between organisations employing community nursing staff, due to resource considerations of people, time and money.
Major resource implications for Trusts offering clinical placements to CHCNs in terms of time spent with student, grading of teachers, and effect that involving a student in clinical practice has in meeting contract targets.
The wide variation in the skills of CHCNs in area of needs assessment. This has implications for edcuation and development for the current workforce as well as role modelling and education of future students.

Figure 12.5 continued

Recommendation 4. *Developing the high-level skills required for the full spectrum of needs assessment should be centred around developing skills of professional judgement.*

4a Education should continue to be minimally at level three (degree level) and consideration should be given to extending opportunities for post-graduate qualifying courses.

4b The opportunity to acquire a sufficiently wide repertoire of experience in different needs assessment situations. The length of time spent in the practice situation, and the quality and range of experience need considering.

4c Given the centrality of the role, the level of preparation for community practice teachers may need to be upgraded

Expert 7:

It is doubtful whether there are many (?any) really expert role models that students could work alongside, given the changing face of community care and its lack of clarity regarding its aims, objectives etc. Is there a role for "proxy" or other experience in the form of video taped assessments that would help students gain expertise to a certain extent ?

The disjunct between professional perspectives on quality of life, service outcomes and the views and perceptions of carers are often markedly different, and might be a useful area to examine in the final report.

Expert 8:

The diffuse nature of community working may mean that opportunities for CHCNs to work beyond grade specification are numerous, but may lead to practice where there has been inadequate preparation.

Paragraph explaining view that needs assessment hinges on professional judgement, and that in order for this model of working to be viable, practitioners need supervision and support. Then writes"In the current somewhat judgmental and punitive climate, that support for practitioners could not be guaranteed."

Expert 9:

"One would expect graduates to be able to conceptualise, most can, but you cannot depend on it given the current experience in higher education...."

"It is quite clear from case studies that some of the teaching is poor, the lecture material is sometimes outdated, and some staff ill-prepared for what they are required to do, even though courses have been validated ! I would urge you to say that this is not acceptable on professional course."

"A means by which newly qualified community nurses can be guaranteed continuing support for a specified period of time seems to be suggested by the evidence. And then, some means of continuing professional study for the remainder of their careers should be an encouragement as well as provide support."

Figure 12.6

Recommendation 5. *Time should be given within the educational programme to enabling students to develop the emotional and personal maturity to accept professional responsibility.*

Expert 1:
No comment.

Expert 2:
Too general, not sure about feasibility.
Wonders whether emotional and personal maturity evolves as individuals confront difficult situations, and therefore whether they can be developed "to order".
Given the study findings the important area of ethics in needs assessment should be covered, which might partly address the need for emotional and personal maturity.

Expert 3:
This is too general, although I agree. More detail as to how this could be implemented in the reality of a programme would be helpful.

Expert 4:
Agree with the sentiment, but time to develop emotional and personal maturity sounds like an "expensive luxury". Would it not occur anyway over the formal learning of the course ?

Expert 5:
Feasible and useful to community nursing.

Expert 6:
This is a key issue in dealing with client expectations, and has implications for recruitment and retention.

Expert 7:
No comment.

Expert 8:
No comment.

Expert 9:
"If there is a positive gain from 'maturity' then perhaps a gap between first level qualification and specialised study should be recommended and the period specified. A means by which the detail of your recommendations are included in course structures is required otherwise the present inadequacies will continue"

Figure 12.7

Additional Remarks.

Expert 1:
Recommendations too broad and general,given wealth of material that precedes them. Go through educational requirements systematically, then frame specific recommendations related to them.

Expert 2:
Excellent working paper. I have relatively few substantive points to add.
My comments are largely about how recommendations might be interpreted.
The recommendations refer to the policy driven aspect of needs assessment, but do not give sufficient emphasis to the need to develop students' understanding of policy. The NHS and Community Care Act has shown that it is the practitioner who works out the practical pathways of implementation of policy in practice. In a period of change, this presents educators and students with an acute problem. Educators need to develop a much closer alliance with practitioners in these instances so that students are prepared for uncertainties of practice, derived from practically derived knowledge and critical debate.
Expectation that need might be sought at community level did not seem to emanate from practitioners, rather from the research team.

Expert 3:
I wonder what implications the method of individual case study analysis has on the cross case study analysis. More explicit links between the findings presented in the individual case study analysis and the cross case study analysis would be helpful.

Expert 4:
All recommendations, except 5 seem to be useful and feasible.
Given the centrality of commissioners in needs assessment, I would have expected to see explicit mention of purchasing in the recommendations.

Expert 5:
The findings reflect previous research about learning in practice, and show that there are still problems. One reason for this may be that they are difficult to address. Perhaps the recommendations could be made more explicit with concrete recommendations. It seems that there should be strong statements in the recommendations about curriculum content and clinical practice experience and objectives.

Expert 6:
No comment.

Expert 7:
Might be useful to do some crystal ball gazing at the end of the report.
The idea that clients and carers have clear expectations of services is questioned by the literature, which shows that have few opinions about what constitutes a legitimate need or service requirement. New legislation about the Carers Services and Recognition act is now relevant.

Expert 8:
The conclusions of this study inadequately acknowledge the work of others.
Problematic definition of needs assessment evident in study, as used differently to mean aggregated needs of communities by community physicians.

Expert 9:
"I regard this as an excellent study ... the whole of the report has a positive and helpful aura about it"

Conclusions.

Generally, our panel supported the recommendations, and offered the research team insights into the way in which they may be interpreted. They also indicated issues in the recommendations which required further elucidation and description, which provided an important dimension to the study recommendations.

Since the comments from our expert panel were received, the research team has revised the recommendations, so that they are more detailed. Where our study findings support additional suggestions from the experts, these have been included. The final section of this report will present these amended recommendations.

13. EDUCATIONAL IMPLICATIONS

Overall, the expert group approved the general thrust of the initial educational implications, but, as shown in Chapter 12, made various helpful suggestions and requested additional clarification and detail. The recommendations have been revisited with their comments in mind. The interim recommendations were based on the empirical results of the study, and the varied comments of the expert group were useful in recalling the broader context of needs assessment, and the contested values and beliefs which persist within this field. It is also pertinent to mention two other changes which have occurred during the period of the study, which are relevant to the education of community nurses and which need considering alongside the educational implications.

First, data were collected from practitioners who were prepared in 'traditional' courses which ran for a calendar year (51 weeks) at diploma level. The idea of the 'specialist discipline of community health care nursing' was first proposed in 1991 (UKCC 1991), and proposals for implementing this into educational programmes were accepted by the UKCC three years later. The implications have been written with these new requirements in mind, as they are to be implemented in all courses by 1998 (UKCC 1994). There are three significant changes from the traditional education. First, presuming that students entering the programmes are already diplomates, the academic level is set minimally at first degree level (level 3). Second, the minimum length of the programme has been significantly reduced, and can be completed within a 32 week period. Third, there is an expectation that programmes should devote equal attention to theory and practice; this has been interpreted to mean that half the time for learning and half the assessment should apply to practice, and half to theory.

Notwithstanding the results of this study, therefore, the challenge for community nurse educators is to enable their students to achieve a higher academic level in a shorter time, at a period of unprecedented change (with associated need for new knowledge) within the NHS. Multiple changes are taking place within higher education, as well. Unlike pre-registration nurse education, community nursing has been always been taught in higher education institutions. However, in many cases, the absorption of the former hospital based schools of nursing into the university sector has created marked reconfigurations to the departments within which community nursing was formerly taught. The amount of change which community nurse teachers need to accommodate at the current time is, therefore, very great. In view of this, and the concern expressed by some of the experts about the capacity for community nursing educationalists to be able to take on board the initial recommendations, attention will be paid to their role and how they might achieve the changes.

The second major change is to the way in which community nurse education is planned and financed by the NHS. Since implementation of the NHS & Community Care Act, educational funding had been administered by Regional Health Authorities (RHAs) under the terms and conditions set out in 'Working Paper 10' (DoH 1990c). Absorption of RHAs into NHS Executive regional outposts in April 1996 led to new administrative arrangements, which cast NHS Trusts more directly in the role of educational purchasers; local and regional educational consortia have been set up to administer the manpower planning and educational requirements of the service.

There has been long attention paid to the idea of a 'theory - practice gap', and this report has explicitly focused on how a series of gaps can open between the intentions set out in the curriculum and the end result in terms of learning for the student. However, it has also focused attention on a 'strategy - practice gap' which, likewise, opens as the spiral is drawn from ideals and plans to provision and eventually into practice. Many of the difficulties encountered by practitioners seemed amenable to change only by managers and others who were in a more powerful position than themselves; the extent to which education can take responsibility, for example for resource constraints, is necessarily limited as it lies outside their remit. However, as purchasers of education, the consortia are in a position to ensure that the opportunities for learning in the practice field are available and suitable. Where appropriate, therefore, attention will be drawn to issues of relevance to the quality assurance aspect of their role.

Central to the aims of the study and the analysis are the educational needs of the community nurses themselves, and this will remain the main thrust and focus of the recommendations.

Developing practice

- *Needs assessment skills appear central to all community nursing, so their acquisition is intimately linked to the development of specialist community health care nursing skills.*

This first recommendation made to the expert group restated a central finding of the study. One expert expressed surprise at this 'statement of the obvious', but given the contested nature of needs assessment, it is not necessarily accepted by all parties. However, it represents the starting point for all the recommendations, since it explains the attention which is paid to developing in practitioners a capacity to exercise professional judgement and a breadth of understanding in their entire role.

There is a need for the standard, kind and content of the whole curriculum to reflect the requirement for a practitioner who is able to exercise autonomy and professional judgement across the diversity of situations and levels which she is likely to encounter in practice. The cross case analysis in chapters 8 - 11 revealed how gaps may arise, then repeat and accumulate through different levels of service provision. In some respects, it helps to focus as well on the different levels and types of learning which students need, to enable them to 'bridge the gaps' of learning, as shown in Figure 13.1.

Theoretical Content and Academic Level

The first gap draws attention to the need for learners to develop a sufficient level of critical ability to be able to assimilate and understand the fundamental knowledge and theoretical basis for needs assessment. Academic levels and the knowledge to underpin specialist community nursing assessments are highlighted. The analysis indicated that many practitioners had considerable difficulty in conceptualising the notion of 'need' apart from the context in which it was applied, which may have led to subsequent difficulties. The courses under review were all validated at diploma level, which, as outlined above, will no longer be permitted after 1998 (UKCC 1994).

The findings in this study appear to support the planned move to graduate level education, suggesting that an ability to conceptualise should be established at level three (an assumption which was subsequently questioned by one of the experts). The following recommendation was suggested:

- *Developing the high-level skills required for the full spectrum of needs assessment should be centred around developing skills of professional judgement. This requires the development of critical skills, ability to conceptualise and articulate practice, education should continue to be minimally at level three (degree level) and consideration should be given to extending opportunities for post-graduate qualifying courses.*

Before outlining the theoretical background to this initial recommendation another obvious point needs stating. Needs assessment is an essentially practical activity, which gives rise to a need to consider issues of theory and practice. Carr (1995) reviews the various theories of theory and practice. He traces back to Aristotle ideas about the 'common sense approach', the 'applied science' approach and the 'practical approach', acknowledging the value in each way of learning. However, he proposes that an approach drawn from Habermas' critical theory can preserve the value in each of these, but will also enable practitioners to become more

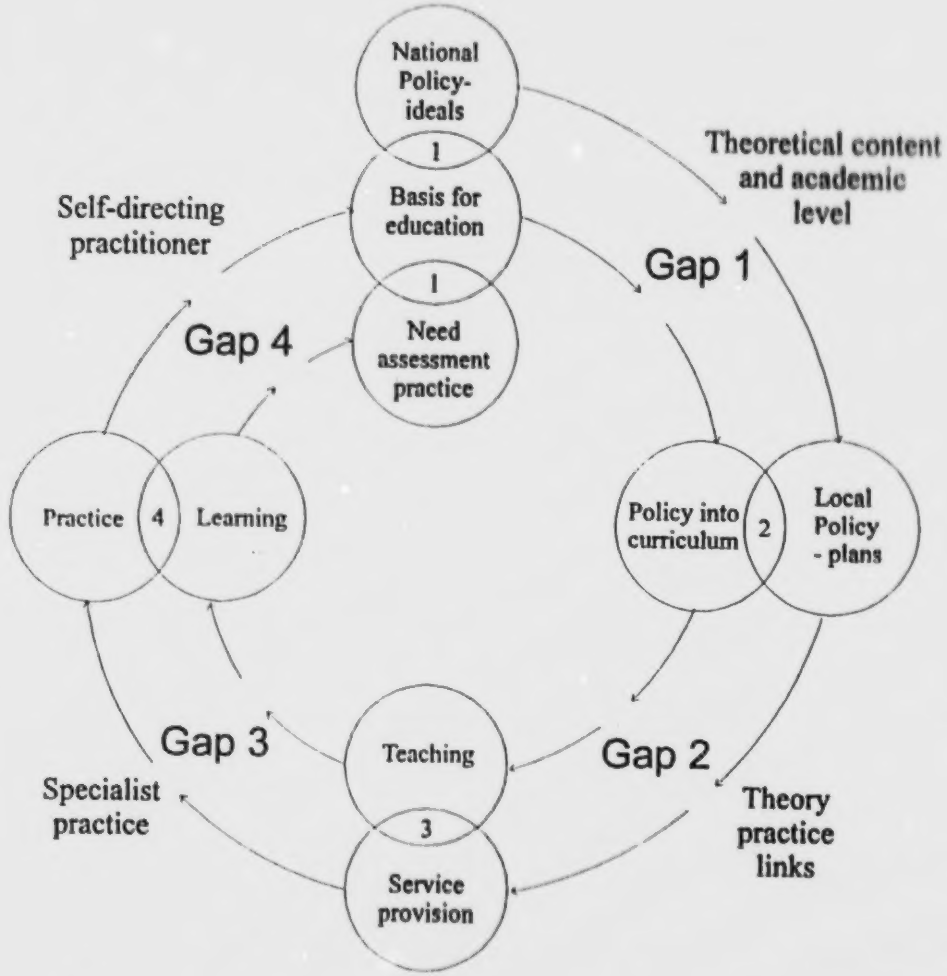
National Policy-ideals
1
Theoretical content and academic level
Basis for education
Self-directing practitioner
Gap 1
1
Gap 4
Need assessment practice
Practice
4
Learning
Policy into curriculum
2
Local Policy - plans
Gap 3
Teaching
Gap 2
Specialist practice
3
Theory practice links
Service provision

Figure 13.1 Curriculum: Standard, Kind and Content

self-conscious about the causal determinants of their beliefs and practices, leading to a greater rational self-control and moral development.

There are very practical reasons rooted in the data (to be considered below), for suggesting the implementation of a 'critical approach' to developing the knowledge base of community nurses. It is essentially a moral approach which is designed to develop the ancient Aristotelian virtue of *phronesis* or 'practical wisdom'. *Phronesis* is a kind of active practical enquiry, concerned with determining what should be done 'for the best'; it is central to professional judgement and considering how to develop it (Fish 1995). It is essentially concerned with developing the capacity of the individual to exercise this practical ability and wisdom, which is distinct from the kinds of practical skills required for productive activity.

This seems relevant, given the number of practitioners who seemed to have an imperfect understanding of the 'policy ideals' needed to underpin assessment, and the apparent conflicts with the nursing ideals which they had learned, either at first level training or through their additional community nursing courses. Community nurses need a knowledge of the policy, as well as an understanding of how policies established at a national level are translated into working practice locally. The implementation of the NHS and Community Care Act was sufficiently new to be unfamiliar to students entering community nursing courses in 1994. While this situation may improve if subsequent cohorts gain information through first level nursing education or experience, it will remain an important part of the basic knowledge required by community nurses.

Indeed, the gaps revealed in this analysis indicate that practitioners need a full understanding of any policy which has an impact on their practice, if they are to contribute fully to the assessment and delivery of health care in the community. There are clear principles to be grasped about the rights of consumers, and about the roles and responsibilities of different agencies and practitioners working within them. This is a necessary basis if community nurses are to achieve their potential as advocates, either on behalf of clients or in facilitating self-advocacy.

The emphasis on developing critical ability should not be considered separate from a basic understanding of the issues, for it cannot occur without sufficient attention to the 'factual basis' for needs assessment. What seemed apparent in this study, was the limited extent to which the students were exposed to ideas about needs assessment other than those based in nursing ideals. The 'holistic ideals' which underpinned the approach to assessment adopted by the majority of practitioners may have stemmed from their first level nurse training, and potentially been extended in their community nurse education.

However, the specialist level of practice required pointed to a deeper and, in many respects, different level of basic knowledge required to underpin the assessments undertaken by community nurses. Much of the required knowledge appears intertwined with the general acquisition of specialist practice ability. This requires practitioners who are able to question their own practice, and if necessary explain why they believe so strongly in a holistic nursing approach, for example.

Furthermore, the rapidly changing contexts in which the practitioners worked and the conflicting, mixed messages which arise from the various different policies even at national level (let alone as they are translated into local strategies) demonstrate the importance of practitioners being able to critically analyse and understand of the basis from which they are expected to work. The difficulty many practitioners had in distinguishing the needs assessment practice from the rest of their work gave rise to a further initial recommendation.

- *The particular skills and knowledge required for needs assessment (especially for formal and structured assessments) require highlighting, to aid clarity and the learning process. It is important that students understand the different ideals which underpin needs assessment according to their basis in holistic nursing or policy-driven perspectives, as* *well as understanding the various types, and the way the timing of assessments varies according to different clients', practice and service requirements.*

The observation and analysis indicated that, despite the similarities in many principles of assessment, there were distinct differences between the knowledge needed by health visitors (e.g., strongly linked to child development, nutrition, health promotion) and district nurses (e.g., used knowledge of pathology, pharmacology and physiology to a greater degree). This lends support to the current view (UKCC 1994) that different areas of practice within community health care nursing have distinct learning requirements. However, there were great areas of commonality; for example, district nurses appeared to use developmental knowledge in respect of ageing, and biological knowledge supported the information and activities of many health visitors. This supports the view of one expert that it is the context in which the knowledge is applied that determines which particular aspects are required.

The issue of what constitutes specialist knowledge, and how this relates to a more general knowledge base and to interdisciplinary working will be considered further below. However, when considering which theoretical topics should be included in the curriculum, the following recommendation was made.

- *The principles of needs assessment should be taught as part of the common core between all community nurses, and some aspects of this learning might beneficially be shared with students from other disciplines, such as trainee general practitioners and student social workers. However, there remains a particular base of knowledge to underpin assessments made within the different areas of community nursing practice, and extra attention should be given to these within the specialist modules.*

There is a need for this information to be imparted to students in a way that takes account of 'real world' constraints on resources, and the political and ethical dilemmas faced by purchasers and providers. Practitioners also need to develop the ability to express themselves clearly verbally and in writing, pointing once more to the importance of the academic level of practice. It is only if they are armed with this fundamental base of knowledge and ability that practitioners will be in a position to relay the dilemmas and difficulties they face in practice in a language which is meaningful to purchasers, including GP fundholders.

To summarise, the analysis begins by drawing attention to the first decisions to be made in planning any educational programme: the level of critical ability required for practice; specific topics and the basic knowledge required, and the context in which the knowledge will be used. The next section focuses more closely on this latter issue.

Theory - practice links

The issue of how knowledge is acquired and used arises immediately within any practice-based education. Students need to learn about the different ideals, types and timing of needs assessment; as demonstrated in the analysis the links between theory and practice and between policy and practice are apparent at every stage of the needs assessment process. In the data, some practitioners appeared to be experiencing a sense of powerlessness themselves, as they struggled to make sense of apparently mixed messages, since local strategies and targets seemed irrelevant to the needs of their clients. Practitioners did not necessarily understand how different needs become recognised within service plans or appreciate the influence of different perceptions of 'health' and its link with need, of service structures (e.g., health and social) and contract specifications, so they were not well placed to make representations about their own clients at trust or purchaser level.

The data demonstrated, for example, that when assessing needs, practitioners were often faced with practical and ethical dilemmas involving different priorities and perceptions within families, between formal agencies and their clients/users, and in dealing with interdisciplinary working and resource allocation issues. Some of the experts linked this to the management situation and resource constraints, and suggested developing an understanding of ethics in order to help. Certainly these resourcing issues remain outside the control of the educationalists teaching the students. However, they can help by equipping neophyte community nurses with a deeply ethical and practical wisdom, the ability to incorporate theoretical perspectives into everyday thinking and to integrate finely judged decisions into practice. Learning about ethics as a separate academic exercise is considered unhelpful in achieving this depth in professional education, as it tends to encourage the separation of theory from practice rather than considering it as a single whole (Moline 1986).

Instead, developing the high-level skills required for the full spectrum of needs assessment should be centred around developing the overall capacity of the practitioner to exercise professional judgement in dealing with intricate situations and difficult dilemmas. The notion of *'phronesis'* introduced above provides the link between the development of ethical ability, professional judgement and practical action, as Carr explains:

> '. . . what Aristotle calls *phronesis,* we would translate as 'practical wisdom'. *Phronesis* is the virtue of knowing which ethical principles apply in a particular situation. . . . . Without practical wisdom, deliberation degenerates into an intellectual exercise, and 'good practice' becomes indistinguishable from instrumental cleverness. The man who lacks *phronesis* may be technically accountable, but he can never be morally answerable. Hence, 'practical wisdom' is manifest in a knowledge of what is required in a particular moral situation, and a willingness to act so that this knowledge can take a concrete form. . . . 'Judgement' is thus a crucial term in the equation linking deliberation and practical wisdom with action. Deliberating well is a mark of *phronesis* , and *phronesis* is the union of good judgement and action.' (Carr 1995: 71-72)

It follows from this, that practitioners who have not clearly understood the different ideals which underpin a holistic, informal nursing assessment of need, and a formal 'needs assessment' undertaken within a policy framework, may well encounter dissonance and misunderstanding; this point was echoed by several of the expert group.

The initial recommendation about these issue were expressed in relation to the learning processes and opportunities required to develop professional judgement:

- *Developing the high-level skills required for the full spectrum of needs assessment should be centred around developing skills of professional judgement. This requires the opportunity to acquire a sufficiently wide repertoire of experience in different needs assessment situations. Both the length of time spent in the practice situation, and the quality and range of experience available should be the subject of serious consideration by educational consortia.*

Three issues arise. First, there is a need to consider the processes by which students develop the kind of *praxis* which occurs when theory and practice are integrated at a single point of understanding. There is an important role here for the lecturers, in enabling them to develop this understanding but - and this is the second point - some of the expert group and some of the practitioners in the study, doubted their capacity to fulfil this expectation. The third issue relates to the need to build a context-based repertoire of experience of needs assessment, and the place of community practice teachers in facilitating that.

Some further explanation of the notion of *praxis* is required to develop the first point. Grundy (1983) developed the prevailing views about the nature of curriculum, explaining how learning about the theory which underpins practice requires an approach which is qualitatively different from a simple adding process. Carr (1995) points out that, while the term 'practice' is used a rough equivalent, there is no direct translation from the original Greek. He outlines three important respects in which the knowledge needed for *praxis* differs from the practical knowledge required for 'making something'. First, the end of practice is not to produce an artefact or object, but to realise some morally worthwhile 'good'.

However, practice is not a neutral instrument by means of which this 'good' can be produced; it cannot be 'made', it can only be 'done':

> Practice is a form of 'doing action' precisely because its end can only be realised through action, and can only exist in the action itself (Carr 1995: 68).

Finally, the practice cannot be understood as a form of technical enterprise designed to achieve some externally related end; Carr (1995) suggests it is a form of morally informed or committed action. He points out that in the ancient Aristotelian tradition, all ethical and political activities were regarded as forms of practice. Given the ethical, moral, evaluative and politically highly contested nature of needs assessment, it becomes clear that a simple development of 'practical skills' will not suffice; true *praxis* is required.

Fish (1995) explains the value of students entering into a critical 'practical discourse' with their lecturers. Drawing on the work of Brookfield (1987) and Carr (1993), she details strategies which can be used to develop students' practical reasoning and ability to engage meaningfully in critical enquiry. In a parallel idea to Schön's (1983) proposed 'practicum', a safe environment in which practical skills and abilities can be developed, Fish suggests there is a need for a sheltered 'praxicum' within which to enter the kind of questioning and stimulating dialogue through which students can students can theorise about their own practice. In practical terms, this could allow students to rehearse in college the inevitable tensions and contradictions between the different sets of requirements they meet in practice, possibly joining at times with students from other disciplines to develop an understanding of different agency requirements.

This kind of practical discourse would enable students to be better prepared to recognise, judiciously consider and deal with some of the ethical and political dilemmas when they arise in practice, and appears similar to the approach used in the 'good practice example' of teaching used in the so-called 'reflective chronicle' encountered in Case M. Students need to appreciate the equal importance of being able to assess needs using a formal or an informal approach, but to be able to distinguish which is appropriate for the presenting situation; and to contribute to service specifications which acknowledge the full spectrum of assessments. Different levels of assessment (individual, family or community) may also occur with varying degrees of formality. The attitudes which underpin 'partnership' working with clients are fundamental, and were generally well understood; however, the skills required to turn this ideal into reality are not automatic, and may easily be undermined by conflicting demands. A further recommendation is proposed which stresses the importance of this kind of teaching.

- *Lecturers should be encouraged to engage in 'practical discourse' with their students in college, to facilitate the development of critical ability and the basis for professional judgement. This teaching should be acknowledged as contributing to both theory and practice.*

The final sentence in this recommendation stems from awareness of a simple practical difficulty in developing a teaching approach which eschews artificial divisions between theory and practice. Regulations for validating courses stipulate that learning time on specialist practitioner courses must be '50% theory and 50% practice' (ENB 1996 p4.27, para 2.1). The underlying philosophy of paying 'equal attention' does not seem to be breached by proposing an approach which combines theory and practice in a single discourse; it is only if closely specified interpretations and time measurements are stressed that a problem would arise. However, if this recommendation is to be implemented, it would be helpful to have a form of words in the regulations which acknowledge that some useful forms of teaching transcend the so-called theory-practice divide.

Turning to a more serious difficulty, several of the 'experts' cast doubt (some quite strongly) on the ability of the community educationalists to understand the fundamental changes which have taken place in the NHS. This echoed the point made by the practitioners in all the cases, since there were criticisms throughout the data of the way the NHS and Community Care Act

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was taught. In some cases the practitioners expressly wished they had been given an opportunity to 'talk things through' on their course. In other cases, this had clearly been attempted, but explorations of dilemmas and conflicting explanations had been incomplete, perhaps leaving students even more confused and uncertain. The proposed 'practical discourse' (Fish 1995) is a highly sophisticated form of teaching which requires from the teacher an even deeper practical wisdom than that which is being developed in the learner.

However as stressed above, community nursing lecturers are, themselves, working in a highly uncertain and rapidly changing educational world, with considerable pressure from many different directions. Working in universities, they face the fundamental difficulty of trying to absorb the new values, attitudes and cultures which have become embedded in the everyday working practice of the NHS trusts, but of which they may have no direct working experience. This study did not draw sufficient data from educationalists to comment directly on the effectiveness of their current knowledge, although it should be said that the lecturers who contributed to the focus group data and who assisted in obtaining the sample gave every impression of commitment to their educational task; there are undoubtedly specific and very real difficulties to be faced. There is, perhaps, a need for a separate examination of the continuing educational needs of this particular group of teachers, and to explore ways in which their practical ability can be maintained. This may be considered as a potentially useful future research project, and is included as an additional recommendation.

- *Consideration should be given to a formal research investigation of the continuing development needs of educationalists teaching on specialist community nursing courses.*

In the meantime, it is possible to make some suggestions. Lecturers are encouraged to spend specific periods of time 'in practice', although there were no data in this study to demonstrate how this was interpreted in the case study sites. Importantly, though, the analysis demonstrated that needs assessment cannot be considered as a collection of separate, superficial 'skills' or 'tasks'. It is an activity which is deeply embedded within the whole context, not only for the individual clients, families and communities which are being assessed, but also within the whole working context for the practitioners who are carrying out the assessments; this is the basis for stressing the need to develop *phronesis* and professional ability overall.

Given the multitude of trusts and vast areas served by single educational institution (as shown in chapter 5, which detailed the large number of trusts accessed in each site), it becomes quite unreasonable to expect lecturers to be personally familiar with every possible context. Furthermore, the small number of students in training - perhaps one or two students from each specialist area of practice, per year, per trust - suggests that the popular model of 'lecturer/practitioner' applied with larger cohorts is unlikely to be suitable for many community nursing programmes. Nor is it likely that occasional, highly circumscribed or very part-time contact with individual clients will bring visiting lecturers into contact with the deep conflicts and dilemmas that arise when needs assessment is viewed as a continuing process which is central to issues of caseload management, of marketing and feeding information up through managers to purchasers or of choosing between different priorities within an area. There is a real importance, therefore, to the place of the community practice teacher in enabling students to grasp the situated meanings and difficulties which may arise in practice; this will be considered further below.

However, two expert group members suggested that engaging in research activities would be a more meaningful way for lecturers to develop a deeper experiential grasp of the nature of the 'new NHS'. Furthermore, there was evidence that several of the trusts might have benefited from a clearer direction about how to collate caseload and community health needs data. There may be a place for community lecturers to develop consultancy roles in assisting with these issues. Apart from an awareness of the values and culture of the NHS, it seems important to pay direct attention to the working environment for lecturers. Universities are generally eager for their staff to engage on what is sometimes seen as their 'core business' of developing and generating knowledge. Given these comments, a further recommendation is added:

- *Lecturers should be encouraged to engage in consultancy work and in research activities which take them into the field of community nursing as a means of keeping up to date with current issues in practice.*

The third issue which featured in relation to theory-practice links concerns the opportunity to practice (in the sense of 'try out') the different approaches. The related, equally important consideration of what constitutes 'specialist practice' will be considered further below. There is a range of literature concerned with the manner by which practice-based expertise is developed (e.g. Benner 1984, Eraut 1994, Schön 1983). Despite the different emphases which can be found in the literature, there is agreement about two issues: it is important for learners to be able to 'try out' their developing skills in a sheltered situation (a 'practicum'), and for them to have the opportunity to build a full repertoire of experience. This did not always happen to the practitioners participating in this study; particular concern has been expressed about how limited the opportunities were for them to witness (let alone practice for themselves) a full, formal joint needs assessment carried out under the terms of the NHS and Community Care Act.

However, this is not the only important issue. The degrees of complexity encountered in assessment situations vary widely from a single or specific issue, through a range to multiple, interlinked or interdependent issues. Awareness of overall policy and knowledge of the different needs on their caseload is not sufficient; practitioners require a knowledge of service availability, and of who else might assist the client whose needs are being assessed. The analysis pointed to referral situations as a potential area for interdisciplinary misunderstanding; referral skills (whether receiving or making) are not straightforward and need to be specifically taught. This is a local issue; ideally, the community practice teachers could introduce the students to practitioners from other agencies to help increase awareness of how different services operate, which will additionally be beneficial in promoting collaborative working in practice.

In summary, this section has focused on the context in which the knowledge will be used. It illustrates how misunderstandings and restricted ability to assess needs may occur if there are gaps in the initial knowledge base, and the importance of setting the knowledge within a local context to avoid opening gaps between theory and practice, and between local strategies or policies and practice. The importance of this link becomes most apparent in the next stage, which is wholly focused on practice.

Specialist Practice

There are three further issues to be considered under this section. First, some comment is required about the nature of 'specialist practice' and what this means. The role of the community practice teacher in facilitating learning opportunities and reflection on practice requires consideration. Third, the availability of suitable learning opportunities and environments will be explored, along with the contribution of the educational consortia in facilitating them.

District nursing and health visiting qualifications have always been at post-basic level, and there has been a long recognition that community nursing practice requires something beyond the straightforward transference of first level nursing ability to a different setting. When the 'Project 2000' courses were first proposed, it was suggested that a higher level of practice witnessed in the clinical nurse specialists and in the community specialists would still be required (UKCC 1986). This was formally acknowledged in the final recommendations for community nurse education, which implemented the idea of the 'specialist discipline' of community health care nursing (UKCC 1994).

Overall, the new programmes of learning are required to have up to two thirds of their teaching within a 'common core', with at least one third remaining specific to the particular qualification. However, as outlined above, the knowledge used in practice seemed more likely related to specific principles rather than specific situations. There were some differences in the fine detail in practice, which emphasises the importance of learning within the practice situation. However, the testimony of data from this study is that the notion of 'specialising' is more closely related to levels of ability than to discrete, circumscribed knowledge. There is, perhaps, the opportunity to increase shared learning with students from other disciplines as well as across the community nursing field.

As suggested above, the increased practice skills required for needs assessment appear bound up with the whole of community health care nursing practice. The data suggested that a number of practitioners depended heavily on prior experience and learning, but only carrying forward nursing approaches learned at first level registration appears insufficient for the higher level skills needed for the diversity of needs assessment situations encountered in the community. There appears to be a particular need to teach the more structured and systematic approaches to assessment, since these were so rarely encountered in the data. Eliciting past and present needs experienced by the client may be facilitated by the use of specific assessment models, which require practice and skill to understand and use. Where they existed, specific opportunities to apply different assessment models did appear to help the practitioners to develop the skills. However, assessment approaches only really became meaningful when utilised in practice, emphasising the importance of ensuring opportunities for this learning are available.

Practitioners also need to practice the use of frameworks for family assessments, which will not usually have been encountered in first level nursing practice. The timing of assessments needs to accord with clients perception of need, for example; this may vary from one family member for another (perhaps in instances of terminal illness or suspected developmental delay). Students need the opportunity to observe, discuss and practice these sensitive assessment situations, to develop the decision-making and interpersonal skills to negotiate such potential dilemmas and conflicts.

There is an opportunity to share learning with students from other disciplines. Apart from creating a better basis for collaboration, this would help to balance (although should not replace) the over-emphasis on the use of nursing models as the sole basis for needs assessment. Debating the relative merits of different approaches and priorities across agencies may help practitioners to learn the skill to handle potential anger or dismay if needs cannot be met or if conflicting priorities arise within caseloads.

There are two 'essential requirements' for students during their period of learning. First, the literature in developing expertise testifies to the importance of building a good repertoire of experience in a variety of situations (Benner 1984, Mackenzie 1992, McMurray 1992). The participants in this study were no exception, and it was significant that certain needs assessment experiences were more difficult to obtain than others. Second, and of equal importance, is the relevance of having an opportunity to discuss these 'practice' events with an expert 'coach' or role model, who can reflectively facilitate the student in learning from the experience (Fish et al 1991, Schon 1983). To this end, a particular recommendation was formulated about the nature of teaching in the practice environment.

- *Central to the quality of learning through practice is the opportunity to observe an expert role model and teacher in a variety of learning situations, who should subsequently be able to reflectively discuss, coach and debrief the student following her own practice in needs assessment.*

At present, it is usual for this 'expert role model' person to be a 'community practice teacher' (CPT) who has been specifically prepared for the role. However, this role was not mentioned in the final PREP report (UKCC 1994) which set out the educational requirements for community health care nursing, and as this report is being written, the UKCC are engaging in a consultation exercise about the standards of preparation for teachers; anecdotal anxieties abound that the CPT preparation will no longer be mandatory. The experiences of learning in practice reported in this study were not universally good, although the credibility of the CPTs generally remained high. One of the expert group suggested that their preparation should be at Masters level, while another doubted whether there existed any 'experts in needs assessment' and proposed instead the use of videos for students to develop their learning.

In view of these diverse opinions, it seems important to explain quite clearly that importance is attached to this role because of the wholly embedded and context-bound nature of needs assessment revealed in the study; in short, because of the nature of the learning task. Throughout, the data and analysis repeatedly demonstrated that needs could not be wholly or meaningfully assessed as a single, one-off event. Nor was it possible to detach the process of needs assessment for one individual or family from caseload responsibilities and needs encountered within the rest of the community served by the community nurse. In view of these comments, it becomes clear that learning in the practice field needs to be overseen by an expert practitioner who holds full caseload responsibility.

Additionally, given the comments in the preceding section, it is important that the CPT is able to facilitate the level of learning required for specialist practice; for this, it does seem important for them to have reached a more advanced level of understanding of their practice than the students they are helping to prepare. There was nothing in this study to support suggestions that community nursing students could adequately learn the needs assessment skills they require without an expert role model and facilitator of learning in the practice field. Therefore, the initial recommendation made to the expert group is retained, along with the additional reference to the level of preparation undertaken by these practitioners.

- *Given the centrality of their teaching role, the level of preparation for community practice teachers may need to be upgraded.*

Indeed, the importance of the community practice teacher as an expert role model and facilitator of learning was apparent throughout the data. Professional judgement is acknowledged in the literature (Eraut 1994, Schön 1983) as a competence which must be developed in and through practice, with 'reflective debriefing sessions' playing a central part in this (Fish et al 1991). This reflection on specific episodes of practice, firmly situated within the context in which it occurs, is both necessary and distinct from the parallel 'practical discourse' (Fish 1995) which was proposed in the last section. The latter is not in any sense detached from practice, but it focuses on the more general knowledge required, on the abstract but crucial principles which underpin ethical dilemmas and judgements and developing the foundations which inform professional judgement - on developing the practical wisdom known as *phronesis* (Carr 1995). However, this does not replace the need for *praxis*, the 'making action' of practice which is necessarily context bound and requires full, informed reflection on activities which have been, in the first instance, observed by students, and later engaged in as they begin to try out the new skills for themselves. The importance of reflecting after the event is central to learning in any practical learning situation, but since the student will often be unsupervised (because of issues of distance and intrusion into people's homes) when carrying out the new assessment activities, the skill with which reflective debriefing is carried out assumes particular importance.

Furthermore, as with the development of any practical expertise, there is a need for the students to be able to build a full repertoire of experience of a wide variety of different needs assessment situations. There are clear principles which link the different approaches. However, these are only likely to become meaningful when the practitioner has developed sufficient confidence in at least some of the approaches to recognise the principles and aspects which are either transferable or distinct between them. Hopefully, the analysis and resulting 'taxonomy' of needs assessment will have helped to clarify some of the fundamental issues, and so aid teaching. A basic requirement, though, is for students to have access to sufficient experience of needs assessment in the practice situation.

There was a sense in which collaborative (especially interagency) working was seen as a specific, separate approach, associated solely with the NHS and Community Care Act. Paradoxically, joint working was also part of 'everyday work', demonstrated through teamwork within and between disciplines, in primary health care teams and health centres. It may be helpful, as with the teaching of need and needs assessment, to make explicit both the similarities and differences between formally constituted situations when joint working is mandatory, and everyday good practice. This may be most helpfully demonstrated in the practice situation, with local joint strategies and plans as a reference point to compare with the particular team situation to which the student is attached.

It is a source of concern that only one joint, formal assessment under the NHS and Community Care Act was observed during the study and that all practitioners expressed difficulty obtaining sufficient experience during their taught practice period. Given the reduction in minimum length of programmes since these data were collected, it may be even more difficult for practitioners to gain sufficient experience, or the time to develop their own expertise through practice and reflective debriefing sessions with their CPTs. This is a contracting issue; unless trusts are able to facilitate sufficient experience in the minimum period it may be necessary to maintain longer programmes. Accordingly, an additional recommendation is made for the educational consortia:

- *Educational consortia need to consider the quality, variety and type of learning experience available in the practice situation. If needs assessment experience and availability of community practice teaching time is limited, the length of courses may need to be extended.*

The analysis suggested that the practitioners in this study were not always able to make full use of the data collected through needs assessment. Health needs profiles of the caseload or community/population for which practitioners are responsible could be used to enable their perceptions of clients needs to enter the policy framework, for example, in a way that jointly reflects and influences purchasing decisions. Given the ambivalence about caseload profiling in some cases, especially on the part of district nurses who were already over-stretched, it may be helpful if this skill is taught in a way that directly relates caseload profiles to caseload management. This may also help to focus attention on the way that organisational structures facilitate or hinder the recognition of different types of need. However, it is also a matter of learning about accepting responsibilities which some may prefer to leave to 'managers'. The issue of professional responsibility features in the final, brief section.

The Self-directing Practitioner

While this concluding section is the shortest, it could be argued that it is also the most significant, in that it considers what might be viewed as the 'final outcome' of the spiral of teaching and learning engaged in by the student. The comments above about the nature of specialist practice are relevant, since this is not merely concerned with the client/practitioner interface (although that remains central and important), but with the administrative and managerial issues which impact upon it. Thus, community health care nurses need the ability to take responsibility for contributing to the development and implementation of strategies and plans which influence the care delivered to the client, whether through compiling community profiles, the construction of new record formats for use in a trust or careful caseload management. Furthermore, even if they encounter needs which are unfamiliar or a new and different situation, they are unlikely to have anyone to turn who is more senior than themselves (at least, in their own discipline) within the trust or primary health care team.

It was awareness of the very demanding situations in which community health care nurses work which gave rise to the last recommendation which was sent to in the working paper to the expert group. It was the recommendation which received the most mixed responses:

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- *Specific time should be given within the educational programme to enabling students to develop the emotional and personal maturity to accept professional responsibility for helping to influence factors which have an impact on their practice, as well to continuing to develop their own knowledge base in relation to new developments.*

In general, the sentiment was applauded, although how it could be operationalised and assessed within a formal programme of study gave rise to concern and to requests for further clarification. The expanded explanations given above about *phronesis* and *praxis* and how students can be helped to develop this practical wisdom and practice ability will, hopefully, have clarified the aim, and remove the need for it to remain as a separate recommendation. However, there is one final concern which needs addressing, relating to the transition from student to specialist practitioner.

Throughout, the likelihood of practitioners meeting very real dilemmas, or simply a hugely unpredictable diversity, in needs assessment practice has been stressed. Furthermore, importance has been attached to these specialist practitioners being prepared to a level which equips them to accept responsibility for taking suitable action to respond to the problems which they meet in practice. One member of the expert group implied that such autonomy lay at the heart of many of the difficulties encountered by community nurses; he suggested they should limit themselves to the activities required of them by their employers.

However, that comment appears out of step with recent changes within community and primary health care, where community nurses are increasingly expected to work without strong management support - indeed, they are their own managers. Furthermore, as demonstrated by the very variable level of support available to the neophyte practitioners, as soon as they are qualified as community health care nurses, practitioners need to be immediately able to operate with more or less complete independence. The variability of the preceptorship period experienced by participants in this study suggests that this cannot be regarded as an extension to the learning period; indeed, in a minority of cases, it became a most testing time, with established practitioners in an area discouraging innovation or with the neophyte working with no peers of the same discipline in the immediate team.

Former 'traditional education' for community nurses included a set three month period of 'supervised practice' which allowed a partly protected transition period into the new role, but this is no longer a requirement under the new regulations (UKCC 1994). The transition from student to newly qualified specialist practitioner may well, therefore, be even more sudden than that experienced by practitioners in this study. The final recommendation is suggested as an alternative to the one above, and deserves particular consideration by the educational consortia.

- *Specialist community health care nurses are required to accept a high level of professional responsibility for influencing factors which have an impact on their practice, as well to continuing to develop their own knowledge base in relation to new developments. Particular attention is needed to the transition from student to qualified specialist, and to ensuring that practitioners are able to work independently by the time they qualify.*

The data in this study did not shed any direct light on the place of 'supervised practice' in easing this transition, although a number of practitioners volunteered their own opinions about the importance of this period in allowing them to develop the confidence and acquire the repertoire of experience as a necessary basis for their needs assessment practices. There was nothing in the study to support the idea of removing this protected period of consolidation; restoring it may be the most straightforward way of achieving the above recommendation. In conclusion, the final recommendations will be summarised.

Implications to be considered by the English National Board

When this study was commissioned, the fifth and final research aim was 'to develop recommendations for future educational provision in community nursing programmes, relating to needs assessment'. The whole of the third phase of the study was directed at refining these recommendations by subjecting them initially to the scrutiny of an expert group, then finalising them for presentation. Since the study was commissioned, the ENB have requested that recommendations be formulated in terms of implications to be considered by their policy board, rather than as direct recommendations.

What follows, therefore, are the issues which have been raised by the study, which require attention in future educational provision in community nursing programmes, in relation to needs assessment. Rather than being listed in the order in which they appear in the chapter above, the recommendations have been collated under common headings. Minor adjustments have been made to the wording and a small amount of explanation added, so that they can serve as summary and be read independently of the preceding chapter.

1 Issues relating to needs assessment and community nursing

1.1 Needs assessment skills appear central to all community nursing, so their acquisition is intimately linked to the development of specialist community health care nursing skills. This point is central to subsequent recommendations and highlights the importance of a curriculum which links professional skills to the diverse practical situations where needs assessment (and its learning) occurs

1.2 Certain aspects of needs assessment were learned better than others, perhaps due to a lack of clarity and understanding about some of the embedded features of need. Therefore, the particular skills and knowledge required for needs assessment require highlighting, to aid clarity and the learning process. Interpersonal and communication skills necessary to elicit variable and individual perceptions of need were generally afforded more attention in curricula than the specific measures required to undertake formal and structured assessments; both aspects are equally important. Students also need to understand the different ideals which underpin needs assessment according to their basis in holistic nursing or policy-driven perspectives, the various types of needs assessment and the way the timing of assessments vary according to different clients', practice and service requirements.

1.3 Specialist community health care nurses are required to accept a high level of professional responsibility for influencing factors which have an impact on their practice, as well to continuing to develop their own knowledge base in relation to new developments. The availability of post-qualifying support and preceptorship periods appeared very variable, so the students must have developed this capacity prior to completion of their courses. Particular attention is needed to the transition from student to qualified specialist, and to ensuring that practitioners are able to work independently by the time they qualify.

2 Issues relating to needs assessment and joint working

2.1 The principles of needs assessment should be taught as part of the common core between all community nurses, and some aspects of this learning might beneficially be shared with students from other disciplines, such as trainee general practitioners and student social workers.

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2.2 There remains a particular base of knowledge to underpin assessments made within the different areas of community nursing practice, and extra attention should be given to these within the specialist modules. For instance, health visitor knowledge appeared more strongly linked to child development, nutrition and health promotion, while district nurses made greater use of theory related pathology, pharmacology and physiology. The data hinted that self-confidence in one's own professional knowledge base, and respect for that knowledge from colleagues, assisted interprofessional working.

3 Issues relating to needs assessment and professional judgement

3.1 Developing the high-level skills required for the full spectrum of needs assessment should be centred around developing the capacity of the practitioner to exercise professional judgement. This should encompass a deeply ethical and practical wisdom *(phronesis* ; Carr 1995), the ability to incorporate theoretical perspectives into everyday thinking *(praxis;* Carr 1995) and to integrate finely judged decisions into practice.

3.2 Professional judgement requires the development of critical skills, ability to conceptualise and articulate practice. Education should continue to be minimally at level three (degree level) and consideration should be given to extending opportunities for post-graduate qualifying courses (masters level).

3.3 Lecturers should be encouraged to engage in 'practical discourse' (Fish 1995) with their students in college, to facilitate the development of critical ability and the basis for professional judgement. This could take the form of students rehearsing and questioning in college the inevitable tensions and constraints of different requirements in the practice situation. This teaching should be acknowledged as contributing to both theory and practice.

3.4 Central to the quality of learning through practice is the opportunity to observe an expert role model and teacher in a variety of learning situations, who should subsequently be able to reflectively discuss, coach and debrief the student following her own practice in needs assessment (Fish et al 1991, Schön 1983). The important role of the caseload holding specialist teacher in the practice setting (community practice teacher) was highlighted in the data.

3.5 The development of professional judgement requires the opportunity to acquire a sufficiently wide repertoire of experience in different needs assessment situations. Two separate but linked issues were raised which should be the subject of serious consideration by educational consortia:

a) the length of time spent in the practice situation, and the quality and range of needs assessment experience available, and
b) the availability and quality of community practice teaching time

If suitable needs assessment experience and/or availability of community practice teaching time is limited, the length of courses may need to be extended.

4 Issues relating to teachers of needs assessment in community nursing

4.1 Study data in this research did not allow for comment on the effectiveness of current knowledge of educationalists. However, it did suggest real difficulties in teaching in an uncertain and rapidly changing environment in community nursing education and practice, which warrant further exploration. Consideration should be given to a formal research investigation of the continuing development needs of educationalists teaching on specialist community nursing courses.

4.2 Lecturers should be encouraged to engage in consultancy work and in research activities which take them into the field of community nursing as a means of keeping up to date with current issues in practice and maintaining practice credibility. Holding a caseload is not generally feasible for university lecturers, nor is occasional, highly circumscribed and part-time contact with individual clients necessarily appropriate for maintaining specialist skills.

4.3 Given the centrality of their teaching role, the level of preparation for community practice teachers may need to be upgraded. Consideration should be given to a post-graduate qualification, since it is considered important for them to have a more advanced level of preparation than the undergraduates they are helping to prepare. The programme should also enable practice teachers to facilitate the high level of reflective learning described above (Fish et al 1991, Schön 1983).

14. EVALUATION OF THE METHOD AND RECOMMENDATIONS FOR FUTURE RESEARCH

In general, it was felt that the three stage design - incorporating focus groups, case studies and an expert panel - served the research well, enabling a focussing upon, and verification of, data which triangulated upon the research aims. However, a number of issues arose during the conduct of the research which would seem to warrant attention, in terms of their facilitatory or inhibitory effects.

Timing

The timing of the research exerted an influence on the study in three main ways. Firstly, the period in general was one of great change for community nursing in terms of both practice and education. Such a time of transition proved at once a positive and negative feature of the research - positive in that it provided for it an underpinning *raison d'être* (the nature of needs assessment clearly being subject to change under the NHS and Community Care Act) - and negative in that researching a concept subject to change is inevitably problematical; findings can, at best, be no more that a snapshot in time and place. This was reflected in the variety within the findings across the case study sites.

The second issue which related to timing concerned the more specific time plan for the research. Research timetabling was largely dictated by the contract period set with the ENB and meant that much activity related to phases one and two (making contacts, arranging data collection etc.) was conducted over the summer months. This was unfortunate, since many educational institutions and personnel were less accessible during the academic "low season", and considerable time was lost here.

The third issue concerned the constraints on time allowed for the very detailed data analysis over three phases (and two levels within the case study phase). The research team necessarily had to be selective and very focussed here. While this was in no way considered to be at the expense of methodological rigour, it did delimit the extent to which related issues could be highlighted as potentially worthy of future research.

Access to research sites and subjects

While, in general, responding subjects and sites in all three phases were supportive of, and interested in, the research, recruitment was hampered in two ways. Firstly, as noted in chapter 5, negotiating with the numerous ethics committees and trusts involved delayed the operationalizing of the research design as planned. A "catch 22" situation has already been described where trust managers would consider the research only when ethics committee approval was granted, while ethical approval was contingent upon indication of participants' willingness. The necessary "dovetailing" of procedures here proved challenging.

Secondly, and again previously noted, it was felt recruitment of participants may have been enhanced by a more personal, interactive approach between the research team and the student cohorts. This feeling was based on the greater success noted where individual lecturers had been encouraged to discuss the study with a group of qualifiers prior to their receiving information. However, time constraints once again precluded this approach.

Data collection

The nature of the data collection, entailed the four researchers each taking responsibility for one case study site. Cost and time constraints although not the only factors, were influential in determining the rationale for this approach, which inevitably had implications for reliability across sites. Yin (1994) suggests that reliability may be enhanced in case study research in two ways - the use of a case study protocol and developing a case study database. The general aim of these strategies is to make the steps involved as operational as possible and "to conduct the research as if someone were always looking over your shoulder" (Yin, 1994, p.37). Both of these approaches were adopted in the present study through adhering to the written research proposal (or protocol) and by discussing and documenting experiences which were thereby shared with other members of the team.

Additionally, the research assistant was (metaphorically) in a position to "look over the shoulders" of the other researchers (and they hers) through her participation across all sites. Joint piloting, analysis of each others' data and cross-case analyzing further exposed each researcher's work to the scrutiny of the others, thereby ensuring a marked degree of consistency.

Data analysis

The perennial issue of time constraints also affected this stage of the research. Though the data were harnessed toward meeting the initial aims, it was felt they perhaps had more potential than could be exploited within the timetable.

The first stage of individual case analysis, involving tabulating interview data, resulted in some differences in "categorization" across the four sites, as discussed. However, this served to strengthen, rather than detract from, the research design, since it reflected the particular features of each case. It also facilitated the replication logic of the cross-case stage, since theories about the conditions under which certain manifestations existed began to emerge.

The adapted use of the model of Parasuraman et al (1985) as a pointer to quality was felt to be an asset at this stage. The researchers acknowledge the possibility of a charge of subjectivity being levelled against them in view of the flexible approach to its operationalization - indeed, much discussion tool place regarding where to place particular data examples thought to be relevant to more than one "gap". However, it was felt both to refocus the researchers, at this important stage, upon the central issues of the research, and to ensure relevant data were not excluded. In other words, a degree of overlap was felt to be more justifiable than the risk of omission of data, in view of the iterative nature of the analytic process, and the fact that it was not intended that "gaps" be considered mutually exclusive.

Project management

The project was managed on a joint basis within the research team, with regular, documented meetings forming the basis of this. The model was felt to have paid dividends in the long run, since it allowed cross-fertilization of ideas amongst professionals with different backgrounds in terms of community nursing and research experience. Inevitably the working through in this way of decisions and problems related to the research were time-intensive but not time wasteful. The steering group served to support, confirm or suggest alternatives to, management decisons arrived at by the team and further contributed to the cross-fertilization of viewpoints.

Opportunities to present papers and posters at two ENB conferences, and to prepare short papers for publication enabled the researchers to clarify thoughts and achievements prior to writing the final report. Despite the distractions these posed at the time, and the unexpected extra commitment in terms of cost and time, they proved valuable opportunities to "take stock" and to produce work capable of subsequent incorporation into the research process.

Recommendations for future research

In the light of the above comments, a number of recommendations are suggested for future research:

- In view of the nature of research in general, which can necessarily only be relevant to prevailing policy, educational and social conditions, it is suggested that further replication of

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the design, using different case study sites, would build up the body of knowledge in the area, supporting (or otherwise) any enduring themes identified in the current project.

- It is further suggested that future topics for research might focus on themes encountered during the current research but precluded from detailed investigation, such as the role of the community nurse in case management, interprofessional working (especially joint assessment) and the more general area of how policy ideals are enacted at field level.

- More specifically, in the field of nurse education, the issue of the pressures, noted in the findings, upon community nurse lecturers are in need of investigation. There appears to be little empirical data so far to suggest how academic nurse teachers may best remain in touch with specialist level practice, while coping with the administrative responsibilities of negotiating placements with several trusts. Such issues could usefully be subject to research.

- The use of the model of Parasuraman et al (1985) as a structure within which to explore service quality issues should be further explored.

- The problems encountered in other, as well as the present study, in gaining ethical approval for multi-site studies supports the need for pressure to be brought to formalize the current working of local research ethics committees, and for the provision of some "umbrella" authority to sanction such studies within one blanket approval procedure.

- Finally, it is felt consideration should be given to increasing the flexibility of timetabling of commissioned research in areas involving educational institutions in order to avoid the situation in the present instance where there was a marked incongruence between research activities and the academic year.

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APPENDICES

Appendix 1(a)

Background Information, Discussion Groups One and Two.

An investigation into the changing educational needs of community nurses with regard to needs assessment and quality of care in the context of the N.H.S. and Community Care Act 1990.

Dr. Kate Young,
Ms. Ann Bergen,
Dr. Sarah Cowley,
Ms. Ann Kavanagh.

Department of Nursing Studies,
King's College ,
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Commissioned by:

The English National Board for Nursing, Midwifery and Health Visiting.

Your role in the group discussion.

The purpose in having a number of people present is so that we can **discuss** an issue, **and learn from each other**. We would like you to **say as much** about the subjects raised **as you feel able**, whilst listening to people with slightly different types of need and opinions.

We are hoping that you will find **this sort of group is a pleasant and fun way** of thinking about some important issues facing today's health service.

In General.

We are thinking particularly about the care you have received from health visitors or district nurses as the focus for our discussion. This will include any assessment of the needs of you and your family.

We are intending to use the material gathered during our discussion to structure similar groups with health visitors, district nurses, the teachers of these community nurses, and the managers involved in the planning of your care. **Together, these group discussions will be used to design a way of interviewing and observing health visitors and district nurses who assess clients needs in their daily work.**

It is therefore important that you feel able to **bring things to talk about which are important to you (or others in a similar situation) to our meeting.** There are **no right or wrong opinions about the issues** we will be discussing, everyone will have their own experiences which will help us to build a good, varied "picture" of issues surrounding what we mean by "need".

We have written some **background information which you may find helpful to read** before coming along to our meeting. It provides a brief introduction to the sorts of issues which we hope you will feel able to discuss with others present in the group. If you can read it and come prepared to talk about some of the issues raised by the questions, it will be very helpful.

The information pack has space for you to write your thoughts and experiences down on paper that you might like to raise during the discussion. **The notes that you make are for your personal use only, you will not be asked to give them to anyone.**

We are hoping this reading material will help stimulate your thoughts around some issues which surround assessment of "need" in todays health service. **Although it will be extremely helpful if you are able to spend some time answering the questions, please don't feel that you have to work through everything unless you want to !!**

INFORMATION PACK.

Many of the experiences you and your family have had tell us a great deal about the way in which we live in todays society. Some of these experiences will be particularly useful to help us to understand how nurses and health visitors work at the moment and how they should change in future. We hope that working through this information pack will help you to think through what is important to people who live in similar situations to yourself.

Different types of need.

There are many different types of need facing people today.

Can you think of any needs you or your family have experienced ? Write them down.

(The following headings might help you identify a variety of your needs :
safety, your local environment, friendship and love, your body, your peace of mind, your local community.)

Think about the things which can affect these needs and list them:

Some of these needs affect whether we use the health service. We are interested in any experiences which you and your family have had which have resulted in a health need (need for information, practical help, a listening ear, or other).

List some examples of your or your family's health needs:

You:

Your family:

Can you think of any things which have meant that you have not wanted or been able to visit the health visitor or district nurse ?

Or any things that have meant that you have been unable to use them in the normal way ? Give any examples of such experiences:

Can you think of any situations which have changed the care you've needed from health visitors or district nurses ?

Assessing needs.

The health service has always been involved in assessing needs within local communities, within particular groups of people, and in individuals.

Can you give examples of any things in your local community which affect health ?

Do you belong to any particular groups of people which have health needs that are different to those of other people ?

If so, what are people's needs in this particular group ?

What are your most important needs as a person at this time ?

What are your family's most important needs at this time ?

We all have needs, but sometimes they are not met, perhaps because we choose to ignore them, or put the needs of others before ourselves. On some occasions needs are not met because we do not realise we have them (we get used to coping without things) or because those around us do not recognise that we have needs that they can meet.

Can you think of any situations where your needs have not been met ?

Why weren't they met ?

What , if anything, have you done about this ?

Before health needs are met, people have to decide that it is worthwhile for them to visit their family doctor, health visitor or district nurse. On some occasions professionals and their clients (patients) may not agree about whether there is a need.

Can you think of any time when you have visited the doctor, health visitor or district nurse where you have felt that you or your family had a need, but the person you visited did not agree ?

Can you think of any time when you have visited the doctor, health visitor or district nurse where the professional felt that you had a particular health need, but you did not agree ?

Health service managers make decisions largely based on their understanding of the needs of local communities, and professionals make decisions largely based on their understanding of theneeds of families and individuals within their care. Managers and professionals sometimes negotiate with each other about levels of funding for different types of care, but clients (patients) were, until recently, rarely consulted about what they felt they needed.

Have you ever been involved in making decisions about the sort of care you or your family have received?

Recent changes to the way needs are assessed.

The way in which managers and professionals working in the health service has been changed because of new legal requirements placed upon them in 1990. Nowadays, local health service managers have been divided into two groups:

- Those who are responsible purely for running and **providing** the services needed by people living locally;
- Those who are responsible for **buying** the services they judge as being needed by local communities.

Managers who buy services (purchasers) **must now ask local people and communities about their needs**, but continue to make decisions about which services are bought on people's behalf. **If the types of health care provided to people is to be appropriate, it depends on managers having a good understanding of what we all mean by "need".**

Can you think of any examples which you think demonstrate that the health service understands your needs ?

Can you think of any examples which you think demonstrate that the health service does not understand your needs ?

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Formal contracts are set up between the managers responsible for buying the care and managers who are responsible for providing the care. These list what services are to be provided, how they are provided, and for what price. **Both managers and practitioners have to function within strictly controlled budgets**, and this sometimes means that they have to prioritise between different sorts of needs and **choose which types of care they can afford** to buy for each type of need.

Wrtte down your thoughts , experiences or questions about this:

Health professionals giving care to local communities work for managers who are responsible for providing services, and **have to fulfil the terms of the contracts set by the two groups of managers**. They still assess the individual needs of their clients, but they have clearer guidelines about how they should assess need and how they should provide care. Because "need" is not an easy thing to define, **there may be occasions where professionals and managers do not agree** about the best course of action for their clients / patients.

Wrtte down your thoughts , experiences or questions about this:

But this **new law** also means that if a need is recognised by health professionals and planned for by managers, they now have a responsibility to respond to that need. **Clients may have a right to certain sorts of care for specific needs as defined by managers.**

Wrtte down your thoughts , experiences or questions about this:

Health professional's assess health needs, but the 1990 law means that **a separate group of professionals at the social services** have overall responsibility to **assess people's social needs**. Although this has always happened, the new law has made much less overlap between the work of health and social care professionals. Because different types of need can sometimes affect the care required, this may, in certain circumstances, be unhelpful to professionals and their clients /patients.

Can you think of any experience that you or your family have had which demonstrates that health visitors or district nurses work well with social workers or people from the social services ?

Can you think of any experience that you or your family have had which demonstrates that health visitors or district nurses do not work well with social workers or people from the social services ?

Kate Young, March 1994.

Things we would like to discuss in our group meeting.

- What comes to mind when you think of your own, or your family's needs ?

- Can you suggest an overall definition or description of what is meant by 'need' ?

- How do you think managers who are buying services should assess the needs of local communities ?

- How do you think health visitors and district nurses should assess your needs ?

- Are there any special points about needs assessment which you think our research should consider ?

Appendix 1(b)

Background 1 - The NHS and Community Care Act (1990) and Community Nursing.

The provisions of the NHS and Community Care Act, fully implemented in 1993, were introduced in an attempt to improve the quality and appropriateness of health and social care delivery. The concept of "need" and its assessment is seen by its architects as being central to this at both a community and an individual level.

Although in the community setting social service departments were given the lead responsibility for coordinating need assessment, the legislation inevitably impacts upon community nurses. and health visitors. By December 1992 health and local authorities were required to have joint agreements in force for integrated assessment, and recent research suggests that in about three quarters of areas surveyed district nurses were instrumental in collecting structured assessment information to comply with this (Philp & Dunleavy, 1994). The figure for health visitors was only slightly less.

The ability to carry out a full assessment of the needs of individuals, families and communities has always held a central place in the practice of community nursing and health visiting. However, the legislation is changing the nature of this practice; assessment is becoming more formalized and is set within an "internal market", with the government encouraging its separation from service provision but also the need to guarantee that provision. Further, there is an imperative to include not only the "consumer" perspective, but also those of other service agencies (especially social services). All this has implications for the education and preparation of community nurse practitioners.

You might like to think about how recent changes in community care have been felt in your district/ locality.

Background 2 - Our research

The ultimate aim of our research is to develop recommendations for the future educational provision of community nurses relating to needs assessment. Later in the study we will be looking at needs assessment in practice, but before we do this we are seeking the views of a variety of groups of "stakeholders" in the process and this is where you come in. We have already had two group discussions with clients/consumers of district nursing and health visiting services and data from these have been summarized and included in this paper.

In the same way your ideas, added to those of the consumers, will be taken to our next meeting with service managers (purchasers and providers) and then to educationalists. In this way we hope to have built up a picture of needs assessment drawn from a variety of perspectives so that we can have a clearer idea of what to look for in our later stages.

> **If you have any comments you would like to make, or questions to ask, about the research and its method we would be pleased to hear them.**

Questions we would like to put to the group.

There are four main areas we wish to discuss in the group session (see separate sheet at end). We considered parallel issues with the preceeding groups and, to get you thinking, you might like to know of some of the ideas and questions they raised, as well as some findings from the literature we have read. These are presented below under the main headings.

1) Needs and needs assessment

The government has defined need as "the ability of an individual or collection of individuals to benefit from care" and needs assessment as "the process of estimating, projecting and categorizing the needs of a local population" (D.o.H., 1993).

Our consumers began with a much wider remit, commenting that need is a very broad concept, covering all of the things basic to life. It was interesting to note that the initial list they produced - money, housing, food, warmth etc. - consisted mainly of physical requirements. However, when asked to consider their own identified needs, they had little problem in articulating what were at once more diverse (extending beyond the purely physical) and more specific (related to their particular situation). The literature also suggests that need is socially constructed and closely bound up with identities, expectations and context (Ong, 1991). Clients may define their needs in either a task orientated way, in terms of discrete episodes of care, or in a more holistic way, which fails to differentiate physical, social and psychological aspects. It has been suggested that only the latter, therefore, require holistic assessment.

Some of our consumers disliked the term "need" itself, since they thought it had negative connotations when interpreted as being "demanding" or "needy". It has been noted that a problem focused assessment may have a detrimental effect on the morale of clients and may result in situations being identified as problems which had not been considered in that way (Caldock, 1992).

Finally, our consumers talked about the way an awareness of need may not always become manifest until it has become overwhelming, when, as one participant said: "you're well into the process of dealing with it yourself". Certainly this idea that a need is "felt" (even if not expressed) is one notion put forward in the literature on need classification (Bradshaw, 1972).

Here are some of the needs our consumers highlighted:

For the disabled:
Practical/physical help - bathing, accessible buildings, transport.
An increased public and professional awareness of disability issues.
Access to specialists, professionals, aids and equipment out of normal hours.
Independence, normality and dignity.
A quick and responsive service for unexpected crises.

For carers of disabled:
Practical help.
Recognition
Emotional and social support.
Out of hours service.
Procedures for dealing with crises.

Carers of young children:
Access to services at convenient times.
Support - someone to "be there" and "listen to you", not necessarily to "do things to you".
Respect and acknowledgment of experience and expertise.
Information - a resource.
Choice and continuity of health professional.
"One-stop-shop" - a central point to approach for any health related need.

Some needs highlighted in the literature which clients want from health professionals are:
Dependability.
Puntuality.
Flexibility.
Continuity.
Intimate knowledge of the care recipient.
Social competence - a professional and caring approach (Ong, 1991).

> **One issue which calls for exploration is the type of client needs which are encompassed within the phrase "needs assessment" with respect to district nursing/health visiting.**

2) Managing the assessment of community needs.

Needs assessment information is used for planning, audit, resource management and contract monitoring. Our consumers had a number of ideas about the way needs should be assessed at both a community and an individual level.

Both groups thought a general awareness of the community by managers was essential, whether this was achieved through visiting health centres etc. themselves or using survey data to collect information on numbers of clients in specific groups (pregnant women, children with special needs etc.). One group felt managers should be drawn specifically from the same health background as the practitioners they manage, so that they shared their cultural viewpoint. Another point made by both groups was that managers should directly access consumer views by involving them in consultative planning groups and acting on their recommendations.

The literature supports much of what our consumers said. It suggests that managers use a wide range of sources of infomation relating to population needs, including extrapolating from national data and more local surveys (D.o.H., 1993). It further suggests that this should integrate with individual needs infomation in the shape of carers' and users' views, individual professional assessments etc.

Information about the needs of communities can be drawn from a number of sources in a variety of ways and we are interested in hearing how this works in your area.

A major concern, again voiced by both groups, was of the budgetary constraints that potentially limit managers' response to need and hence may colour their approach to need identification. The issue of falsely raised expectations in assessing needs was very evident and one mentioned in the literature. This suggests that the use of information in a piecemeal fashion results in provision which is demand, rather than needs, led (Jacoby, 1990).

Another issue to consider is the response which should be made when it is envisaged that resources will not provide for all anticipated needs.

Recipients of health visiting services were also concerned that emotional needs should not be overlooked - those such as support which, traditionally, health visitors were practised at meeting, but which were not visible or directly measurable. It was felt to be important that managers should listen to professional practitioners in this respect, since they had a good knowledge of individuals, families and communities.

The respective role of managers and practitioners in assessing needs of communities was unclear and you might like to think about your experiences and ideas on this.

3) Assessing individual client needs.

The issue of how to bring needs to the attention of professionals brought forth some degree of agreement from our groups. They both mentioned the merits of self-initiated action through self-help groups and the like but at the same time found asking for help was sometimes difficult, particularly for people who were not articulate. This was also difficult where people were not sure of what services were available or no professional contact existed. There was, therefore, a need for an enabling role from professionals to help people realize their needs. This duality is reflected in the literature; studies have discovered that some clients like to be proactive in bringing needs to the attention of district nurses and health visitors, while others prefer the professionals to set the parameters (Ong, 1991, Chalmers, 1993).

The problem of how clients with health needs can be accessed when they are not known to the "system" is one which needs to be considered.

Another interesting area of tension was seen in the view about assessment formats. "Checking" in the sense of "seeing you are all right", was seen by health visitor users as useful as these professionals know what to look for. However, it was also seen to have negative connotations in the sense that it could become "checking up" ("snooping") or seen as adopting a "checklist mentality". The literature reports that many community nurses use structured, established instruments, such as the Barthel Index, CAPE, carer stress ratings or an explicit nursing model, such as Roper. The limitations are acknowledged, although they can provide useful and well validated frameworks.

An alternative was put forward by our consumers in the form of assessment through "getting to know" the client. It was felt that this could only come about when there was continuity in the professional/client relationship, since change was perceived as creating instability here. It was also felt that a caring, supportive attitude, which avoided stereotyping by client group was conducive to this and the promotion of a true partnership with the client was vital to this "knowing". The literature suggests that the "getting-to-know-you" approach, though user friendly, can be time consuming and problematical for practitioners (Richardson & Higgins, 1991).

> **You might like to think about the relative merits of structured and less structured assessment formats.**

Our consumers were interested to know how community nurses saw themselves as members of teams, because they identified a major role for liaison work with other professionals in meeting needs. Some felt it was unhelpful to have too rigidly defined boundaries between professions and thought that nurses may feel threatened as members of teams. Certainly the need to share information between health and social services, and considering what should be shared and how, is on the government agenda (D.o.H., 1993). Other commentators point out that in some 90% of districts health professionals already share information with others in health and social services through multidisciplinary teams, case conferences etc. However, there is some unease expressed in the literature related to the prospect of nurses adopting fluid role boundaries where this means taking on tasks outside the nursing remit.

> **There is some debate as to how nurses can effectively liaise with other disciplines in needs assessment.**

A final area of concern for our consumers in securing adequate assessment from community nurses was the potential for conflict, both between clients and professionals, who saw things from differing perspectives, and between clients and carers. The recognition that carers have needs distinct from (and often in conflict with) those of the client, gave rise to a debate as to whether they should therefore be assessed separately or whether this may break the reciprocal trust and openness that existed in a close carer/dependant relationship. There is a further issue of potential differences between managers and either practitioners and clients and the government has noted conflict generally to be an area of concern (D.o.H. 1993).

> **Practitioners need to think about how to cope with potential areas of conflict in assessing needs.**

Other issues to consider in needs assessment highlighted in the literature are its ongoing nature, the integration of individual with population needs assessment and the need to improve recording systems. Practitioners also must ask how they can ensure assessment guarantees a link to action and quality care, while bearing in mind the government's emphasis on their separateness.

4) And finally.......

Our consumers made a few other specific points about needs assessment and how it can be developed. One idea was to use liaison workers, not necessarily with a professional background, but with a working knowledge of a given locality, who could bring needs to the attention of community nurses. Another was to have disabled people visit nurse education establishments to promote disability awareness and to have community nurses do the same in schools in order to educate the public.

> **There may be some additional points about needs assessment, and particularly the preparation of practitioners for this, which you feel our research should consider.**

Questions we would like to discuss in the group

1) What client needs do you think are encompassed within the phrase "needs assessment" with respect to health visiting?

2) How should community health needs be assessed and who should be responsible for this?

3) What is the particular role of district nurses in assessing individual client needs?

4) How do you think we can prepare practitioners for needs assessment through their educational programmes?

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Appendix 1(c)

Background and Introduction

The ability to carry out a full assessment of the needs of individuals, families and communities has always held a central place in the practice of community nursing. As well, the skills of community nurses in assessing needs are integral to the requirements of both the Children Act (1989) and the NHS and Community Care Act (1990). However, this recent legislation has changed the emphasis, and perhaps the nature, of practice, with consequent implications for the educational preparation of practitioners.

Accordingly, the English National Board for Nursing Midwifery and Health Visiting (ENB) commissioned this research. Overall, the study aims to identify what information educationalists need to take into account, when planning courses of preparation for district nurses and health visitors, so that they are able to meet the requirements for needs assessment and quality of care within the new legislative framework (Appendix 1 summarises the research aims and design).

This particular part of the study is using a series of focus group discussions, to elicit and clarify a variety of different opinions about needs and needs assessment; these data will be analysed and used to inform an observation and interview schedule for use in the second phase. We would be pleased to hear any comments or questions you have to make about the research. This background paper is intended:

- **to serve as a focus for discussion**
- **to summarise some of the relevant literature about needs assessment and**
- **to give participants an idea of the views expressed by consumers and practitioners in the groups which have already been held.**

At various points, particular issues will be highlighted, and the key questions which we would like to address in the group are listed at the end of the document.

Nature of 'Needs'

The idea that the concept of 'need' itself is personal, subjective, variable and constantly changing goes back at least far as the 1970's in the literature of community nursing (eg, CETHV 1977, Crouch 1978, Luker and Orr 1992, Twinn and Cowley 1992) and of research into needs assessment and classification (Alderson and Dowie 1979, Bowling 1992, Bradshaw 1972, Cartwright 1983).

Our consumers seemed well aware of this shifting focus, and stressed that perceptions may change depending on who was asked, and their particular situation. A link to service provision was acknowledged, but some started from a much wider remit, commenting that need is a very broad concept, covering all of

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the things basic to life. When asked however, they had little problem in articulating their own needs in a way that was at once both more diverse (extending beyond immediately obvious physical necessities) and more specific (relating to their own particular situation), and which demonstrated their expectations and opinions about what district nurses and health visitors should offer.

Recognition of this variability may be integral to respecting client choice. It conforms with views in the literature, that 'need' is a socially constructed concept, which is closely bound up with identities, expectation and context (Ong 1991, Willard 1982). Community nurses have traditionally tried to take this personal-subjective dimension into account, through an individualised approach to assessment which is the initial stage of the nursing process (Clark 1986). The link to future action was implicit in this approach, but it was not associated with any statutory responsibilities.

- **We need to clarify the type of client needs which are encompassed within the phrase 'needs assessment' with respect to district nursing and health visiting.**

The practitioners in our groups recognised the breadth and diversity of the concept of need, but some commented on how an individualised approach was constrained by 'official' views that some perceived needs might merely be 'wishes;' they reported being advised that these should not be assessed as needs, although none had been given any guidance about how to distinguish between these two concepts.

However, some of our consumers disliked the word 'need', feeling it had negative connotations of 'being needy,' or of 'being demanding'. They suggested that it might be likely to generate a negative response from professionals, and wished to express their requirements by perhaps saying "I'd like, . . " whatever it was. This contrasts with recent literature which tends to confirm the practitioners' reports, by distinguishing between needs, wants and services,and emphasising that responsibilities are restricted to the meeting of that which is designated as a 'need' (Philips at al 1993).

Another issue which was raised by both consumers and practitioners, was that of 'hidden' or unacknowledged needs. These tended to refer to potential needs, which may be averted by timely intervention (like support following bereavement), or to needs which did not seem to'fit' the established services, like out-of-hours provision, or someone to listen, support and generally 'be there' for the carer or parent.

The literature reflects the duality which appeared within our consumer discussions, in that some clients like to be proactive in bringing needs to the attention of district nurses and health visitors, while others prefer the professionals to set the parameters (Chalmers 1993, Ong 1991). The literature suggests that unmet need continues to be an issue in the elderly population (Farquar et al 1993), and the importance of identifying vulnerable children is well acknowledged within the Children Act (1989).

- **We need to explore the issues relating to assessment of clients who have not explicitly articulated a need for themselves, and how community nurses should be prepared for this.**

A concern expressed by both the consumers and the practitioners within our focus groups, was that assessment of need was really linked to the available budget, and the current services. The Children Act requires suitable provision to be made for children designated, through a process of assessment, as having special needs. The Community Care Act, likewise, requires a package of care to be devised to meet assessed needs (DoH 1989a).

In each case the assessment is clearly intended to lead to action and responsibilities are explicit. However, our consumers were wary about how these explicit responsibilities might colour perceptions of need among service planners, and the practitioners identified many local difficulties when resources were stretched.

- **We need to consider whether it is possible to unravel the strands of needs, needs assessment and service provision, and to ask whether they can be considered separately, or if they are always linked.**

Government guidelines urge practitioners to view assessment as a separate exercise from the service response (SSI 1991). Nevertheless, they reinforce the view that assessment does not take place within a vacuum, but within a framework of locally determined objectives and priorities (DoH 1990). As well, there is a statutory requirement in the legislation to co-ordinate arrangements for assessing arrangements for assessing community care needs on an interagency basis (DoH 1990, SSI 1991) and collaboration between services is stressed in 'Working Together under the Children Act' (DoH 1991).

Roles in Needs Assessment

Under the NHS and Community Care Act (1990), assessment of need within populations is viewed as a function of senior management, using epidemiological, statistical and research data. These assessments are essential for the commissioning authorities, who are required to determine appropriate service provision according to the identified needs of the population they serve (DoH 1989b). However, the concepts of social need and health need are regarded as separate, and the responsibility of different agencies.

The 'traditional' community nursing view of assessment has always encompassed the social context as well as the person's health status or medical condition. This is extended to include a search for health needs in the population they serve, which was articulated as a function of health visiting over fifteen years ago (CETHV 1977) and of district nursing more recently (Mackenzie 1989, Pritchard 1991).

This activity is supposed to generate a profile which documents an assessment of need at the community or caseload level. These profiles have been flagged as essential for practice for facilitating prioritization, ensuring equity, evaluating the quality and effectiveness of approaches and so practitioners could influence policy decisions (Hunt 1982, Goodwin 1988, Twinn et al 1990). Our practitioners did not seem to have any experience of the data they gathered being used formally to inform service provision, but they gave examples of how they had used it to support particular approaches to practice, or requests for equipment.

The consumers were not sure that a population-wide assessment of needs using statistical datasets could really work, since it took no cognisance of the personal, subjective element of need. They expressed mistrust of 'managers' undertaking this level of assessment, but they were not entirely sure that district nurses should have to identify needs at an area or community level either, since they were perceived as being already 'overloaded.'

- **We need to consider the different roles and responsibilities in needs assessment, at the levels of the individual, the family and the community.**

The district nurses themselves recognised the importance of this community dimension to needs assessment, but, perhaps reflecting that this has only recently been incorporated into courses of preparation, expressed little familiarity with the process. Indeed, despite the importance accorded to the activity in the literature, recent research found little evidence of profiling at either a health authority or practitioner level (Young 1991).

The health visitors endorsed the view that documenting the needs in a profile was often a low priority when they were busy, although some talked of reorganising the way the information was collated so that it could become a 'genuine' working document. However, they talked of prioritising and planning their work in accordance with needs identified in their particular caseload area. Some expressed concern that increasingly close attachment to GP practices since the advent of fundholding was reducing their ability to assess needs at a community level; the difficulties arising from incompatible boundaries for datasets have been noted in research (Chase and Davies 1991, Young and Haynes 1993).

The consumers generally supported the idea of health visitors networking and gathering information in the community as a whole, apparently understanding how this was an integral part of needs assessment, and regarding it as closely linked with collaboration and developing support within a neighbourhood. However, they had little experience of this actually happening, and questioned whether health visitors should have to carry out this activity in their 'own time,' as it was assumed to be an activity which was not supported within their role.

- **We need to explore the links between liaison and networking within the local community, and collaboration within teams and across agencies, in respect of needs assessment**

Social service departments were given the lead responsibility for co-ordinating need assessment for the Community Care Act (1990), but joint working is mandatory and both health and local authorities were required to have joint agreements in force for integrated assessments by December 1992. The district nurses were, perhaps, more familiar with these than the health visitors in our group, who frankly doubted the research which found that almost three quarters of authorities had complied with this directive (Philp and Dunleavy 1994). However, the health visitors were aware of arrangements for joint working in respect of the Children Act (1989).

Problems of role demarcation issues and communication between social services and nursing agencies are well documented (Brunnen and Korczak 1993, Leiberman 1990, Rodrigues 1992, Squire 1993). The practitioners described both duplication and gaps in the service. Issues about continuing accountability raised concern, particularly for practitioners who reported feeling they had no control over future service provision and no way of deciding if a further assessment was required.

As demonstrated in the literature (Higgins et al 1994), too, our practitioners recognised that the 'personal touch' often served as the key to successful joint working, although this was only just evolving in many areas. Once practitioners had met and come to know colleagues from different agencies, it seemed easier to begin to collaborate meaningfully, to develop shared assessment documentation and to trust one another's judgement. This seemed equally true when considering joint working with voluntary agencies, some of whom were represented in our consumer groups.

The Practice of Needs Assessment

There is a requirement that agencies should seek consumer views when deciding which services to provide, and there is an assumption that the views of service users and carers will be taken into account by the professional assessor when planning the particular package of care at an individual level. We received some positive reports in this regard, but some consumers reported a degree of 'tokenism' in respect of service consultation.

At an individual level, they would have liked to have been accorded more 'respect' for the views they expressed, and for the knowledge they had gained about their own situation. However, policy documents that offer guidance to implementing the new approach to needs assessment tend to be prescriptive rather than facilitative; they emphasise the dissemination of information, making service provision clear and explicit, and specifying how assessments are to be documented (SSI 1991). The assumption is that assessment might be carried out successfully in a single encounter. This differs radically from the former 'nursing process' approach, in which assessment is viewed as a continuous monitoring activity, integral to all nursing activity.

Our consumers seemed to like the idea of the much less prescriptive, kind of 'getting to know you' approach to needs assessment. The literature and on-going research indicate that this method remains acceptable within community mental health and learning disabilities fields (Bergen, unpublished data, Richardson and Higgins 1991). However, it requires continuity in the professional-client relationship, and is very time-consuming. These drawbacks may explain the increasing use, in both health visiting and district nursing, of explicit criteria and documentation of need in order for clients to access a service.

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While our practitioners denied emphatically that a full assessment of need could usually be made in a single encounter, they nevertheless reported having contract requirements that required this of them. Some consumers clearly resented the formality of the questioning process and completion of documentation, especially in respect of assessing family health needs for health visiting services, and wanted rather, to receive the kind of services which appeared caring, supportive and individually focussed.

- **We need to explore the implications of the 'documentation approach' to needs assessment, in respect of client choice and participation in care.**

Certain specific assessment scales and tests were recognised, and used with no apparent difficulty. Also, our practitioners were mainly quite experienced, and they described how they had developed skills of assessment which superseded yet encompassed the use of documentation; the records were apparently used mainly as a formalising admission to services, liaison and as an aide-memoire, which accords with recent research into the health visiting assessment process (Appleton 1993).

Like the consumers, the practitioners clearly identified the importance of a confident knowledge base and of developing a caring and supportive approach, in order to elicit the full picture of need and choice from the clients they assessed. Nevertheless, some practitioners reported that in future assessments may be a generic function, to be carried out team leaders regardless of their professional backgrounds.

- **We need to consider the extent to which assessment skills are essentially linked with the rest of the nursing knowledge base, or whether they are partly or fully separate from it.**

The Organisational Context for Needs Assessment

The importance of both clinical supervision and peer support were highlighted as essential elements in the process of assessment. This was particularly evident when there were areas of conflict, perhaps between different needs within a single household (eg, carer and patient, child and parent), if perceptions or priorities differed between assessors from different agencies or service users, or where there were unresolved views about reponsibilities for meeting agreed needs.

The importance of clinical supervision has been highlighted in policy documents (NHSME 1993), but some organisational changes were identified as problematic in this regard, particularly where practitioners were based in multi-disciplinary teams without peers or managers of their own background.

- **There are educational implications if newly qualified practitioners have no 'immediate' access to a peer who can help them to consolidate their skills.**

Some of the consumers also identified issues associated with the organisational structure of the service. Multiple assessments occurred where clients lived 'on the boundaries,' and when contracts were changed from one provider unit to another. Some of the consumers wished to have a say in which district nurse or health visitor was 'allocated' to them - either because they did not like the person who had been sent, or if they wanted to retain links with staff that they knew and liked, rather than losing them because of moving house or changing doctors.

- **Please let us know if there are any additional points about needs assessment and the preparation of community nurses for this, which you think our research should consider.**

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Key questions

- What aspects of 'need' should be encompassed in the educational preparation of district nurses and health visitors?
- What is the role for health visitors and district nurses in assessing needs at a population (caseload/community) level?
- What skills are encompassed in an assessment of needs at an individual level?
- How should practitioners be prepared for carrying out this role?
- Should the preparation reflect only current role expectations, or is a wider awareness essential?

Appendix 1(d)

Background and Introduction

The ability to carry out a full assessment of the needs of individuals, families and communities has always held a central place in the practice of community nursing. As well, the skills of community nurses in assessing needs are integral to the requirements of both the Children Act (1989) and the NHS and Community Care Act (1990). However, this recent legislation has changed the emphasis, and perhaps the nature, of practice, with consequent implications for the educational preparation of practitioners.

Accordingly, the English National Board for Nursing Midwifery and Health Visiting (ENB) commissioned this research. Overall, the study aims to identify what information educationalists need to take into account, when planning courses of preparation for district nurses and health visitors, so that they are able to meet the requirements for needs assessment and quality of care within the new legislative framework (See research summary enclosed).

This particular part of the study is using a series of focus group discussions, to elicit and clarify a variety of different opinions about needs and needs assessment. These data will be analysed and used to inform an observation and interview schedule for use in the second phase. We would be pleased to hear any comments or questions you have to make about the research. This background paper is intended:

- **to serve as a focus for discussion**
- **to summarise some of the relevant literature about needs assessment and**
- **to give participants an idea of the views expressed by consumers, practitioners, purchasers and provider unit managers in the groups which have already been held.**

At various points, particular issues will be highlighted, and the key questions which we would like to address in the group are listed at the end of the document.

Nature of 'Needs'

The idea that the concept of ' need ' itself is personal, subjective, variable and constantly changing goes back at least far as the 1970's in the literature of community nursing (eg, CETHV 1977, Crouch 1978, Luker and Orr 1992, Twinn and Cowley 1992) and of research into needs assessment and classification (Alderson and Dowie 1979, Bowling 1992, Bradshaw 1972, Cartwright 1983).

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Our consumers seemed well aware of this shifting focus, and stressed that perceptions may change depending on who was asked, and their particular situation. A link to service provision was acknowledged, but some started from a much wider remit, commenting that need is a very broad concept, covering all of the things basic to life. When asked however, they had little problem in articulating their own needs in a way that was at once both more diverse (extending beyond immediately obvious physical necessities) and more specific (relating to their own particular situation), and which demonstrated their expectations and opinions about what district nurses and health visitors should offer. The literature confirms the role of health care professionals in facilitating situations whereby consumers can learn to articulate their needs clearly (Wainwright 1994).

Recognition of this variability may be integral to respecting client choice. It conforms with views in the literature, that 'need' is a socially constructed concept, which is closely bound up with identities, expectation and context (Ong 1991, Willard 1982). Community nurses have traditionally tried to take this personal-subjective dimension into account, through an individualised approach to assessment which is the initial stage of the nursing process (Clark 1986). The link to future action was implicit in this approach, but it was not associated with any statutory responsibilities.

The practitioners in our groups recognised the breadth and diversity of the concept of need, but some commented on how an individualised approach was constrained by 'official' views that perceived needs might merely be 'wishes'; they reported being advised that these should not be assessed as needs. Some of our consumers disliked the word 'need', feeling it had negative connotations of 'being needy,' or of 'being demanding'. They suggested that it might be likely to generate a negative response from professionals, and wished to express their requirements by perhaps saying "I'd like, . . " whatever it was. This contrasts with recent literature which tends to confirm the practitioners' reports, by distinguishing between needs, wants and services, and emphasising that responsibilities are restricted to the meeting of that which is designated as a 'need' (Phillips at al 1993).

Some of the purchasers agreed that 'needs' would only be regarded as such if the client could benefit from service provision, commenting on public expectations and sometimes inaccurate beliefs about the function and responsibilities of services. However, there seemed to be a slight trend towards suggesting that need is best conceptualised as "what the client says it is," returning once more to the idea of need as variable and personal in nature

- **We need to consider the kind of attitudes and beliefs that community nurses need to acquire, so they can work confidently with so diverse a concept.**

Need Assessment

Once 'need' is linked to 'assessment', Marshall (1990, cited in McWalter et al 1994) suggests that the purpose must be made clear; the term should not stand alone, but be followed by the phrase "For what?" This approach seems helpful in making a link to service provision, without imposing normatively defined needs onto consumers. They offer a framework for needs assessment which is linked to the provision of help for identified difficulties, especially for people with dementia.

However, that approach would not help deal with an issue raised in all the focus groups, of 'hidden' or unacknowledged needs. In some cases, these referred to unrecognised or potential needs which may be averted by timely intervention; examples included support following bereavement, or relieving social isolation of families leading to developmental delay in the children. In other cases, identified needs did not seem to 'fit' the established services; consumers would have liked out-of-hours provision, or someone to listen, support and generally 'be there' for the carer or parent, for example.

The literature suggests that unmet need continues to be an issue in the elderly population (Farquhar et al 1993), and the importance of identifying vulnerable children is well acknowledged within the Children Act (1989). As well, the literature reflects the duality which appeared within our consumer discussions, in that some clients like to be proactive in bringing needs to the attention of district nurses and health visitors, while others prefer the professionals to set the parameters (Chalmers 1993, Ong 1991).

- **We need to explore how future practitioners address the [illegible] of clients who have not explicitly articulated a need for themselves;**

A concern expressed by both the consumers and the practitioners within our focus groups, was that assessment of need was constrained by the available budget, and linked only to the current services. The Children Act requires suitable provision to be made for children designated, through a process of assessment, as having special needs. The Community Care Act, likewise, requires a package of care to be devised to meet assessed needs (DoH 1989a).

In each case the assessment is clearly intended to lead to action and responsibilities are explicit. However, our consumers were wary about how these explicit responsibilities might colour perceptions of need among service planners, and the practitioners identified many local difficulties when resources were stretched. The provider managers, too, seemed acutely aware of the potential dilemma posed by meeting explicit requirements within a limited budget, but they suggested two positive ways forward. Some social service managers reported negotiating with clients, both explicitly recognising the extent of unmet, assessed need, and being open about the extent of service provision that was possible within the resources; they feared angry demands, but reported relief and co-operation from clients.

Further, the managers stressed the importance of ensuring that service deficits were recorded and articulated in a 'politically acceptable' way to purchasers, so that the service would be dynamic rather than static, and could become responsive to identified needs. In turn, the purchasers stressed the importance of receiving clearly articulated statements of need and how service providers could respond to these; the importance of identifying outcomes was emphasised. However, it was recognised that 'prioritising' within an established budget would continue for the foreseeable future, so some gaps in service provision would inevitably continue. Echoing Richardson's (1994) view that building an explicit framework of values should precede the technical component of needs assessment, the purchasers emphasised the importance of community nurses establishing an ethical and moral basis for their assessment strategies.

- **We need to establish how community nurses can be helped to develop the moral, ethical, and political bases for needs assessment.**

Roles in Needs Assessment

Under the NHS and Community Care Act (1990), the concepts of social need and health need are regarded as separate, and the responsibility of different agencies. Also, government guidelines urge practitioners to view assessment as a separate exercise from the service response (SSI 1991). Nevertheless, they reinforce the view that assessment does not take place within a vacuum, but within a framework of locally determined objectives and priorities (DoH 1990).

There is, however, a statutory requirement in the legislation to co-ordinate arrangements for assessing community care needs on an interagency basis (DoH 1990, SSI 1991) and collaboration between services is stressed in 'Working Together under the Children Act' (DoH 1991). As well, the 'traditional' community nursing view of assessment has always encompassed the social context as well as the person's health status or medical condition. Some of our managers considered that an assessment might constitute part of a service provision; indeed in some cases it may be all that is required. Social services organisations have not all implemented the clear division between purchasing and providing, and GP fundholders are recognised as taking both parts. Thus, the separate functions implied in policy and the literature appears much less clear in practice.

Also, under the NHS and Community Care Act (1990), assessment of need within populations is viewed as a function of senior management, using epidemiological, statistical and research data. These assessments are essential for the commissioning authorities, who are required to determine appropriate service provision according to the identified needs of the population they serve (DoH 1989b). However, community nurses have long experience of this function. The literature in this field extends the idea of assessment to include a search for health needs in the population served; this was articulated as a function of health visiting over fifteen years ago (CETHV 1977) and of district nursing more recently (Mackenzie 1989, Pritchard 1991). This activity is supposed to generate a profile which documents an assessment of need at the community or caseload level. These profiles have been flagged as essential for practice for facilitating prioritization, ensuring equity, evaluating the quality and effectiveness of approaches and so practitioners could influence policy decisions (Hunt 1982, Goodwin 1988, Twinn et al 1990).

Our practitioners had little experience of the data they gathered being used formally to inform service provision, but they had used their profiles to support particular approaches to practice, requests for equipment and appropriate staff. Nevertheless, the managers stressed the importance of practitioners providing them with data from individual records, so that it could be aggregated to provide evidence to purchasers of unmet need. Some of the purchasers explained the importance of obtaining 'soft data' from community nurses that would support their own readily available statistical and epidemiological data. However, despite the importance accorded in the literature, and by both purchasers and managers who clearly regarded profiling as an important part of the community nursing role in needs assessment, recent research found little evidence of this at either a health authority or practitioner level (Young 1991).

The health visitors endorsed the view that documenting needs in a profile was often a low priority when they were busy, although some talked of reorganising the way the information was collated so that it could become a 'genuine' working document. Nevertheless, they talked of prioritising and planning their work in accordance with needs identified in their particular caseload area. Some expressed concern that increasingly close attachment to GP practices since the advent of fundholding was reducing their ability to assess needs at a community level. The difficulties arising from incompatible boundaries for datasets have been noted in research (Chase and Davies 1991, Young and Haynes 1993), but few managers or purchasers in the groups regarded it as a difficulty worthy of attention.

- **We need to consider how community nurses can best learn about assessing needs at the levels of the individual, the family and the community, and how their role complements that of others within the organisation.**

Collaboration and Networking

The consumers in our groups generally supported the idea of health visitors networking and gathering information in the community as a whole, apparently understanding how this was an integral part of needs assessment, and regarding it as closely linked with collaboration and developing support within a neighbourhood. However, they had little experience of this actually happening, and questioned whether health visitors should have to carry out this activity in their 'own time,' as it was assumed to be an activity which was not supported within their role. The awareness of a community dimension to the district nursing role seemed even lower.

Social service departments were given the lead responsibility for co-ordinating need assessment for the Community Care Act (1990), but joint working is mandatory and both health and local authorities were required to have agreements in force for integrated assessments by December 1992. The district nurses were, perhaps, more familiar with these arrangements than the health visitors in our group, who frankly doubted the research which found that almost three quarters of authorities had complied with this directive (Philp and Dunleavy 1994). However, the health visitors were aware of arrangements for joint working in respect of the Children Act (1989).

Problems of role demarcation issues and communication between social services and nursing agencies are well documented (Brunnen and Korczak 1993, Rodrigues 1992, Squire 1993). The practitioners described both duplication and gaps in the service. Issues about continuing accountability raised concern, particularly for practitioners who reported feeling they had no control over future service provision and no way of deciding if a further assessment was required. When these concerns were reported to the groups of managers and purchasers, they did not appear to recognise the difficulties, and tended to attribute the concerns to a transitional phase, and practitioners' inability to adjust to their changing role.

As demonstrated in the literature (Higgins et al 1994), too, our practitioners recognised that the 'personal touch' often served as the key to successful joint working, although this was only just evolving in many areas. Once practitioners had met and come to know colleagues from different agencies, it seemed easier to begin to collaborate meaningfully, to develop shared assessment documentation and to trust one another's judgement. This seemed equally true when considering joint working with voluntary agencies, some of whom were represented in our consumer groups. Again, some of the purchasers considered that this emphasis on 'informality' was unhelpful and encouraged over-dependence on 'individual personalities'.

Despite government emphasis on collaboration between services and the development of locally organised strategic plans, some of the provider managers complained that a kind of ' strategy gap' could arise. Examples were given of situations where purchasers neither collaborated with them, nor took account of identified needs or policy documents, like the 'Health of the Nation' (DoH 1992).

- **We need to explore how community nurses can best be prepared for their role in liaising and networking within the local community, and in collaborating within teams and across agencies, in respect of needs assessment.**

The Practice of Needs Assessment

There is a requirement that agencies should seek consumer views when deciding which services to provide, and there is an assumption that the views of service users and carers will be taken into account by the professional assessor when planning the particular package of care at an individual level. We received some positive reports in this regard, but some consumers reported a degree of ' tokenism' in respect of service consultation.

At an individual level, they would have liked to have been accorded more 'respect' for the views they expressed, and for the knowledge they had gained about their own situation. However, policy documents that offer guidance to implementing the new approach to needs assessment tend to be prescriptive rather than facilitative; they emphasise the dissemination of information, making service provision clear and explicit, and specifying how assessments are to be documented (SSI 1991). The assumption is that assessment might be carried out successfully in a single encounter. This differs radically from the former 'nursing process' approach, in which assessment is viewed as a continuous monitoring activity, integral to all nursing activity.

Our consumers seemed too like the idea of the much less prescriptive, kind of 'getting to know you' approach to needs assessment. The literature and on-going research indicate that this method remains acceptable within community mental health and learning disabilities fields Richardson and Higgins (1991). However, it requires continuity in the professional-client relationship, and is very time-consuming. These drawbacks may explain the increasing use, in both health visiting and district nursing, of explicit criteria and documentation of need in order for clients to access a service.

While practitioners, purchasers and managers all denied emphatically that a full assessment of need could usually be made in a single encounter, they nevertheless reported having contract requirements that required this. Some consumers clearly resented the formality of the questioning process and completion of documentation, especially in respect of assessing family health needs for health visiting services, and wanted rather, to receive the kind of services which appeared caring, supportive and individually focused.

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- **We need to consider the extent to which assessment skills are essentially linked with the nursing knowledge base, and how community nurses can be enabled to develop the degree of sophistication required to carry it out successfully.**

The Organisational Context for Needs Assessment

The importance of both clinical supervision and peer support were highlighted as essential elements in the process of assessment. This was particularly evident when there were areas of conflict, perhaps between different needs within a single household (eg, carer and patient, child and parent), if perceptions or priorities differed between assessors from different agencies or service users, or where there were unresolved views about responsibilities for meeting agreed needs. The importance of clinical supervision has been highlighted in policy documents (NHSME 1993), but some organisational changes were identified as problematic in this regard, particularly where practitioners were based in multi-disciplinary teams without peers or managers of their own background.

- **We need to consider the educational implications if newly qualified practitioners have no 'immediate' access to a peer who can help them to consolidate their skills.**

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The provider managers and purchasers each repeatedly emphasised the importance of community nurses learning to be flexible, innovative, able to respond positively to changing circumstances and to work within the new legislative framework. These abilities seemed to them to be essential aspects of the assessment process.

- **Please let us know if there are any additional points about needs assessment and the preparation of community nurses for this, which you think our research should consider.**

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Questions we would like to discuss in the group.

- How has "needs assessment" as outlined in the Community Care Act, 1990 impacted upon your practice of assessment?

- How can community practitioners be prepared to integrate the professional definitions of need with the clients views of needs, and deal with the issues of unmet need?

- Assessment of need involves moral, ethical, and political dimensions. How can future practitioners be prepared to address these issues in practice?

- What is the Community Practitioners role and purpose in undertaking health needs assessment beyond the individual level?
  How can the processes be facilitated?

- How can educators facilitate the community practitioners in translating theory into practice?
  How can community practitioners be educated to cope with the current "theory practice gap"?

And finally,

- What are the fundamental components of needs assessment which should be taught in order that future practitioners are flexible but comprehensive in their practice?

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Appendix 2: Observation Record

Record

	Site Initials	DN/ HV	Observer Initials	Observation Number	Date Day/ month
Reference Number:					

NHS Trust/ Unit:

Who are we going to see?

Previous contact:

Reason for contact:

Contact arisen through or referred by:

Knowledge prior to visit:

To be completed after visit

Length of Assessment visit

Was it a:	Yes	No	Unsure
First Assessment, Apparently complete?	☐	☐	☐
First Assessment, Apparently incomplete?	☐	☐	☐
Second/ subsequent visit, Apparently complete?	☐	☐	☐
Second/ subsequent visit, Apparently incomplete?	☐	☐	☐
Was a follow up visit arranged?	☐	☐	☐

ENTRY BEHAVIOUR. Did the Nurse/ Health Visitor:

If first contact:	Yes	No	Unsure	COMMENT:
Introduce Name				
State profession				
Say where he/she is from				
Tell how nurse got client's name				

In all cases:	Yes	No	Unsure	COMMENT:
Explain purpose of visit				
Show an awareness of house rules				

DURING VISIT, does the Nurse/ Health Visitor explicitly:

Perception of Need:	Yes	No	Unsure	COMMENT:
Recognise clients view of need?				
Discuss with client service definition of need? **IF YES:**			▨	
Does service want to provide something the client does not want?	▨			
Does service not want to provide something the client wants?	▨			
Service and client agree about need?				
Discuss his/her professional judgement of need with client?				
Allow client to feed into a joint definition of need?				
Attempt to discover hidden, barely visible, or potential needs? ADD COMMENT				

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Reference Number: Date

Eliciting of Need:	Yes	No	Unsure	COMMENT:
Was client reserved or reluctant to discuss particular problems or needs at any time in visit?				
IF YES: Did the nurse/ health visitor acknowledge this difficulty by use of verbal/ non-verbal behaviour?				
Were there areas that the nurse/ HV raised that the client refused/ blocked/ avoided during visit?	▨			
IF YES: Did the nurse/HV show an awareness of client's refusal to discuss area of need?				
IF YES, Did the nurse/HV:				
Close it down immediately?				
Give information?				
Make comment?				
Ask questions?				
"open door" to future discussion?				
Were there areas that the client raised that the nurse/ HV refused/ blocked/ avoided during visit?	▨			
IF YES: Did Nurse/HV show an awareness of client's wish to discuss area of need?				
IF YES: Did Nurse/HV refer to future visits or plans to address these areas?				

Client:	Yes	No	Unsure	COMMENT:
Does the client make suggestions?				
IF YES, How does this arise?				
Active verbal prompt				
Active non-verbal prompt				
Client initiated				
Does the client ask questions?				
IF YES, How does this arise?				
Active verbal prompt				
Active non-verbal prompt				
Client initiated				

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Multiple aspects of need:	Yes	No	Unsure	COMMENT:
Did the nurse/HV comment on the wider effect of a particular need? IF YES, was it,				
On client?				
On immediate family?				
On social network?				

Overt knowledge during Visit:	See key	COMMENT:
What knowledge was explicitly demonstrated by Nurse/ Health Visitor during visit? COMMENT ON TYPE		
What knowledge was demonstrated by client during visit? COMMENT ON TYPE		

Key:

B = biological
P = pathology
PY = psychology
SP = service provision

D = Developmental
PH = pharmacology
R = Research knowledge

E = Ethics of situation
PO = political
S = Sociological

Information giving, was it:	Yes	No	Unsure	COMMENT:
About NHS service provision?				
About other service provision?				
About condition/ need identified?				
About accessing other professionals?				
About accessing other services/ agencies/ organisations?				
About other professionals already involved in care?				

Was there any explicit reference to:	Yes	No	Unsure	COMMENT:
why information was being sought?				
the service response to be recommended?				
Probable areas of need that cannot be addressed by service?				

After Visit Record

Measurements and Records

e.g. What measurements were taken during the visit? What records were completed during the visit? What records does the nurse/ HV say are still to be completed?
(Use nurse/ HV language to describe records and obtain a copy of record sheet used, if possible.)

Communications

e.g. Open/Closed, Relationship centred/Assessment centred, To check client understands, Procedural.

Please note the significant events observed that you will take to interview:

NB. include notes for all ticks in shaded boxes.

Appendix 3

Interview guide

	Site Initials	DN/HV	Researcher Initials	Interview Number	Date Day/month
Reference number:					

1. Attitude/personal philosophy
Needs assessment is a large subject with many aspects. When we mentioned the subject to you, what came to your mind?
prompts: who? - indiv/comm
what need? - health/broader, actual/potential
aim? (for what?)- inform providers actual provision

2. Demonstration of needs assessment
Thinking back on this morning's visits, which would you say best illustrated needs assessment?
prompts: which incidents/episodes illustrate needs assessment?
were there elements of assessment in the other visits?

3. Look for evidence of access to/reading White Paper
Did you learn about the NHS & CC Act in college? From what you know, and have experienced, what would you say are the features which affect assessment?
prompts: joint assessment/interagency working
role of CNs
role of SS
target groups
links to provision
social/health split
client led philosophy
Children Act
Education Act

4. Knowledge/use of theory
Do you use/did you learn at college about any theory of need/need classification/needs assessment?
prompts: Bradshaw
Nursing models
Nursing research

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5. **Knowledge/opinions on documentation**
Thinking about the document you use to assess clients:
do you feel it is appropriate?
how could it be improved/what alternatives are there?
prompts: more/less structured
biographical
client/prof led
(Ask for copy of documentation if not previously acquired)

6. Assessment skills - supplementary to observational data
Can you take me through the process of needs assessment with respect to this client?
What skills and knowledge do you think are needed to undertake such a needs assessment?
Look for: identification of process approach, difficulties, services, unmet/potential needs, plan for service response, plan for evaluation, identification of skills necessary
(Pick up on issues from observation)

7. Knowledge of services
Do you have enough information about the services which might help meet (this) client's needs?
prompts: mention any brought up during assessment & ask what alternatives might be considered
if none mentioned, ask what possibilities in mind

8. Ethical awareness
Do you think this client's needs can be met?
Were there any (other) problems/difficulties encountered during this assessment?
prompts: resource constraints
own limitations
prioritising
differences in client/professional definition of needs

9. Administer continuum grid, asking:
Which descriptor characterizes the assessment you have just carried out?
Which characterizes how you think it would have been given an ideal world?
(Looks for awareness of needs ass as multidimensional, governed by context, ideal/real discrepancies, matching theory to practice)

The continuum of needs assessment

Interview guide

	Site Initials	DN/HV	Researcher Initials	Interview Number	Date Day/month
Reference number:	________	________	________	________	________

Client/needs led	Resource/policy driven
1	6
Structured	Non-structured
1	6
Quantitative/objective	Qualitative/subjective
1	6
Linked to service provision	Separate from provision
1	6
Continuous/ongoing process	A single/one-off event
1	6
One assessor only	Two or more assessors involved
1	6
DN/HV essential to assessment	Other assessor possible
1	6
Based on deficits/problems	Based on strengths
1	6
Health only	Health/social
1	6

10. Context data and awareness (supplementary to documentation)
Does the Trust have a service philosophy which affects your practice?
prompt: can you enlarge on that?
who was involved in framing it?

11. **How do you organise your caseload, in terms of need assessment?**
prompts: involvement in community profiling?

12. Perception of education for role
Thinking back to your preparation for DN/HV practice, do you feel you were adequately prepared to conduct needs assessment?
prompts: can you remember what/how much you were taught?
in what ways could this preparation be improved?

Interviewer's comments:
Items for discussion

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Appendix 4

Needs assessment: framework for content analysis

1. The concept of need

Definitions and perceptions e.g.:
- Variable & changeable and/or static
- Quantifiable & measurable and/or not quantifiable & measurable
- Recordable and/or not recordable
- Hidden & barely visible and/or overt and recognisable
- Subjective and/or objective
- Context bound and/or not context bound

2. Needs assessment

Characteristics e.g.:
- A single event and/or an ongoing process
- A structured and/or non structured undertaking
- Professionally "owned"/social service led
- Health needs only and/or social and other needs

Purpose e.g.:
- Outcomes
- Assessment for what?

3. Individual and family/unit assessment - dimensions and skills e.g.:

- Clients within the context of the family
- Who is the client?
- Family and carer needs assessment
- Conflicts of interest
- Eliciting the diversity of human responses and perceptions
- Specific skills to measure and record indicators of need (i.e. technical ability)
- Specific knowledge of underlying biology, psychology etc.
- Negative examples/missed opportunities

4. Collective needs assessment - dimensions and skills e.g.:

- Compilation and analysis of health needs data in profile format
- Different "levels" of profiling - GP, practice, Trust, caseload etc.
- "Intuitive" profiles (knowledge of needs in area without formal collating) - uses and limitations
- Wider purpose of individual needs assessment and ability to generalise from particular
- Purpose and use to which community profiles are put - synthesizing information for service managers and planners
- Rhetoric and theory vs. reality

5. Working and sharing with clients e.g.:

- Client (as opposed to resource and practitioner) led assessment - seeking their views
- Advocating for clients
- Client held records
- Theory vs. reality

6. Joint/collaborative/multidisciplinary working e.g.:

With colleagues in discipline, PHCT, NHS personnel, social services and other agencies
Formal and overt or presented through avoiding conflict situations
Expressing support or acknowledging role of others
Negative examples, tensions or conflicts

7. Knowledge and provision of service responses e.g.:

Formal service provision including NHS, social services, education services
Informal services including voluntary, neighbourhood, private, commercial
Gaps in provision of resources and ethical issues in meeting needs

8. Community Care Act and political issues e.g.:

Knowledge of the Act and impact on current working practices locally
Structural/organizational issues and sequelae
Funding issues and ethical implications
Decision making and prioritising
Theory and practice

9. Education for needs assessment - content issues

What was taught
What should be taught e.g.:

Communication skills, health beliefs, ethics & politics inc. NHS & Community Care Act, research skills, models of nursing, management & decision making, financial awareness, profiling, skills for generalist vs. specialist assessment

10. Education for needs assessment - process issues

How needs assessment was taught
How needs assessment should be taught e.g.:

Joint (multidisciplinary) learning and course planning, learning through practice, clinical supervision, student led learning such as group work, encouraging students to challenge practice and ensuring educationalists keep in touch with practice

11. Spare file - issues which don't fit into the framework

Appendix 5

Needs assessment - data collection framework emerging from "brainstorm" + lit.

Q1 & 2a - Take as base SSI definition: "*needs are said to show a requirement for individuals to enable them to achieve, maintain or restore a respectable level of social independence and quality of life, as defined by the particular care agency or authority*" (i.e deficit based, individual and normatively defined and based on concepts of dependency and quality of life)
Q2b see below
Q3 from focus group data
Q4 see final column

Focus of data collection	Method of data collection	Content (from brainstorm+lit)	How it answers the Qs
1) Practitioner's philosophy of needs/needs assessment, role concept etc.	Interview ?documentation	-domain mainly attitude -continuum grid:- do you think this needs assessment was.....: do you think it should be..... includes typology (level, type) -personal philosophy	highlights: -deficit in attitude (topic for educational input) -mismatch between theory & ability of practitioner to practice (method/emphasis of teaching)
2) Practitioner's knowledge base	Interview	-domain mainly knowledge -NHS & Comm Care Act requirements/guidelines eg joint assessment, SS roles -theory of needs eg Bradshaw organizational issues from typology eg documentation, approach -services available to meet needs -info. about clients prior to assessment	highlights: -adequacy of content of educational prog or -adequacy of method (how it is recalled when necessary in context)

3) Practitioner's awareness of problems/ethical issues in needs assessment & how to deal with them	Interview (awareness) Observation (how cope)	-domain knowledge/attitude/skills -resource constraints -ideal vs. reality -own limitations -prioritizing	highlights: -adequacy of ethical content -adequacy of practice component in educ - how to cope in reality - ie clinical supervision issues
4) Practitioner's relationship with client	Observation ?interview ?documentation	-domain mainly skills -process of needs assessment - acquiring the info (from McWalter et al) *identify difficulties *is current help adequate? *identify unmet need *what type of help needed? (indep of service) -communication -observstion -empathy -partnership/facilitation -information handling -accessibility -advocacy -flexibility -respect/privacy	highlights: -adequacy of skills related to needs assessment in curriculum - content, method. integration with practice
5) Context of needs assessment	Documents (needs assessment forms, protocols, mission statements etc.)	-typology (organization, approach) -barriers -boundaries -geography/organization -multidisciplinary working -service philosophy	-provides baseline for student awareness issues -highlights potential limits to the educational process

6) Practitioner's perception of adequacy of education	Interview	-general question on how adequately prepared they feel, picking up on specific issues: *knowledge *skills *attitudes *awareness	-provides consumer view of changing educational needs

APPENDIX 6L1: SUMMARY

The concept of need: definitions and perceptions.

ELDNKY01 (10-4-95).
(page nos refer to subsheets)

1. Need seen as holistic - physical mental psychological social cultural whole, including family structure. (p1)

    conflict in components of need (p4),
    managing need / need itself varies according to interplay between components of need - unmeasurable aspects to easily quantifiable task (p4)

2. Most obvious need = medical (interferon injections) (p1)

3. Need is subjective
    social services / DN different definition (p1)
    Health & social definitions of need overlap (eg respite) (p1)
    and
    provision for need is a political issue in these cases (p2)
    client defn. vs prof defn (p3)
    client priority vs prof priority (p3)
    prof involvement in particular (social) client needs sometimes should be justified (p3)
    prof defn vs prof defn (DN-DN) => etiquette (p3-4)

5a. Need as changeable (p3, p4)

5b. Need as static(p3)

6. Need as context bound (p4-5)

ELDNKY 02

Need as deficit (p1)(p9)

Need as subjective
    PT-DN defn / recognition (p1) (p2-3)(p3) (p3)(p4)(p4)
    defn of poverty<=>defn of need (p2)
    subjective and changeable (DN prof. defn changes p6))
    pt dn defn differnece can mean need is not met (p13)

Need primarily about individuals (p1)

Need is hidden
    eg poverty (p2)
    eg. relationship (p2)

have nice environment, but cannot afford to use heating (p9)
forgetfulness (p9)
possible elder abuse (p12)

Need is context bound
hidden need can influence overt need (eg poverty-leg ulcers p2)
presence of an entryphone removes need (p2)
presence of family (p3)
pt "compliance" (p5)

Need is not always addressed directly
eg need for family becomes need for support (p3)

Need as quantifiable (p3)
evidence of possible elder abuse (p12)

Need as hidden, with some quantifiable elements
elder abuse (p12) identified by warning signs, not objectively or directly measurable

Need as recordable
use of nursing models / assessment documents (p8-9) improves vocabulary, but not always practical, Roper is relevant (p9)

Need determined by interplay between components of holistic health (p10) (environment, physical self care, medical self care, personal response to illness -physical, social emotional, financial, previous use of services, medical condition, relationships)

Need as changeable
unpredictable in the short term, senile dementia (p12)
with pt condition, dying pt (p16)

ELDNKY03

Need as individual (but briefly acknowledge is wider) (p1)

Need as subjective
SS-DN defn (p1)
according to model of nursing used (p9-10)
pt-carer perception of need(p11)
DN-pt defn ("right decision for them" p14)
DN-DN defn (p17)

Needs determined by context
home help input (p3)
social eg neighbour (p4)
hosp & home determine need (p5)

- addressing changeable needs constrained by resources / context (p18)

Needs as changeable
- from day to day (physical condition of frail elderly lady p3,p4)
- due to pt attitudes to condition / future (p3)(p11-12)
- over long term (deterioration in elderly p5)
- due to changes in prof. defn of need (p6)(p10)
- according to knowledge of pt (p14)
- according to experience of pt (p16)
- can improve (rehabilitation), (p18)

Needs as hidden
- preventive nursing (p7)
- missing things during assessment (p12)

Need as objective, but hidden from immediate view (bruised arms p3; memory acuity p4)

ELDNKY04

Needs as context bound
- socio-economic structure of area influences need (p1)
- social support (p3)(p10)

Needs as subjective
- DN-Pt defn differ (p1)
- attempt to identify pt defn (p12)
- according to philosophy (p13)

Need determined by interplay of components of health
- social contact - monitoring medication (p1)

Need as changeable
- pt adjusting to new methods of working (p1-2)
- according to provision (p2)
- weight loss (p3)

Need as an interplay between components of health
- help with son-money-anxiety (p3)
- nutrition-wt loss-bowels-pressure sore -tired (p4)

Need as hidden
- DN addressing psychol need whilst washing (p3)

ELHVAK01

Needs as holistic (p1)

familial, environmental, type of area lived in, lifestyle, parenting, child development (p1)
Needs as psychological (p3)
familial, siblings, employment, housing (p4)
need to be listened to (p14)
as support (practical and psychol.p14)

Needs as interplay between the components of health (p1)(p4-5)(p8)
subjectivity comes into defn of need when pt see priorities differently from HV (eg housing - family social problem)

Needs within community (p1)

Needs as barely visible
visit, then think about it, then recognise it (p4)

Need as subjective
taking into account pt view of need when prioritising visits (p4)
as determined by routine visits / checks (p4)
minimised by assessment document, but still present in different professional judgement (p6)
pt hv defn of need (p16)(p20)(p28 =>HV frustration)
?professionally or ?organisationally or ?resource defined (p28)

Need as objective
despite absence of provision (p37)

Need as ever present despite addressing immediate concerns (infinite) (p9) (p11b)

Need as predetermined by standards (p13)

Needs bound by context
hospital /home/ Rx/ medical condition (p17)
individual ability (eg reading, motivation,p22)
equipment (p27)
maternal circumstances (p28)

Needs as changeable
according to context (p17) (p28)

ELHVAK02

"The more I look the more..." (p1)

Subjective
HV-HV (p1)
Need defined jointly HV-Client (p2)
Need defn different for HV-client (p9)(p16)
need defn constrained by resource provision (p16)

Needs bound by context
social relationships of client (p2)(p20)

- money - nutrition (p10)
- self employed - not take time off to drive son for prosthesis (p14)
- socio-economic cirumstances (p`16)

Need as objective
- need there despite absence of service (p14, p15)

holistic health
- developmental, psychological, familial siblings, (p4),
- lifestyle (p11), information (p20)

interplay between components of health
- memory-child safety (p17)
- social - health (p22)

ELDNAK03

Need bound by context
- Housing (p1,p2) (p14)
- familial (p2,p4)
- financial cirumstance (dress, car ,p5)
- local area ethnic mix(p6)

Need as holistic
- communication,psycholog,historical, familial (p4)
- cultural (p5)
- physical, social, emotional, housing amenities, environment,road safety (p11)
- hygiene (p14, p19)
- information (use of lotion for head lice, p19)
- childcare (p20)(p21)

need as subjective
- HV-Client (p14)
- HV-Client disagreement =>conflict (p24)

need as objective
- move someone-housing not problem, its family (p14)
- HV-Hv similar defn of need, despite client disagreement (p24)

interplay between different component of health
- practical need for childcare<=>mental state (p21)

APPENDIX 6L2:SUMMARY

Needs Assessment - Characteristics & Purpose.

Characteristics:	**Comment:**	**Page no.:**
ELDNKY01 A single event & / or an ongoing process	*reassessment each time you visit	p2,p5
	*can't do everything in one visit	p2
	*relationship building	p2
	*better picture of context of need	p2
	*joint visit = one off event, but in context of ongoing assessment of whether health or social need / of pt condition	p3
A structured or a non-structured undertaking	*unstructured notes (blank sheet)	p3
	*structured by logic (Roper/family centred care)	p3
	*would prefer an aide memoire to glance at during assessment	p3
	*client & prof led *? in here*	p4
Professionally owned / social service led	*Joint visits=joint undertaking but ss can be very resistant to suggestions and ideas	p3
Health needs only & / or social & other needs	*health needs because not time facility or knowledge for social => refer	p1
	*involvement in social issues only if justified on health grounds	p5
	*health and social	p6
	*joint assess with consultant,sw, diet, hv if specialist input needed	p2
Ideal vs reality	*Referrals sometimes result in no action 3-4 weeks later	p1
	*time an issue if referral is late in day	p6
	*time of visit determined at times by travel of DN	p6
Specialist nursing General Nursing Core community needs assessment	*early discharge means DNs need to be more aware of hosp procedures	p2
	*specialist knowledge from other prof-consult,sw,hv,diet = joint visit	p2
	*Joint visits =>quicker provision, prevents overloading,prevents repeating info & tests, "done by expert'	p2
	*assessment is something that does not necessarily require a community qualification, as do assess in general training	p6
	*assessment in someones home is different as look at home environment, and DN is in front line	p6-7

Purpose:		
Outcomes	*referrals to another service provider often result in time delay	p1
Assessment for what ?	*To make them better, more comfortable, to enable stay at home, for safety *for further investigation / referral * to identify where DN cannot meet need & find other service *monitoring	p1 p1 p1-2

Characteristics:	Comment:	Page no.:
ELDNKY02 A single event & / or an ongoing process	*First target in on dressing, then look at other areas-social relationship *DN instigates change as get to know pt, encourage pt to take responsibility =>different needs assessed *ongoing to compare with baseline assessment *Try this & see what happens *"I think you're always .. with observation ,, assessing somebody" *ongoing as might not initially be aware of hidden needs *describes a changing need (leg ulcer deterioration) over a period of time which involved variety of different assessments	p2 p3 p3 p3 p5 p9 p9
A structured or a non-structured undertaking	*Structured, but informal *an exemplar of assessment which seems well structured by topic-environ, self care, medical care received, persons reaction ot illness, physicla social emotional, financial, previous use of services, physical condition, relationships *structured by previous experience of pt *structured by pt query *structured by day and time of visit, unstructured by order of assessment activity	p9 p10 p9,p10 p10 p13
Professionally owned / social service led	*DN essential for wound care	p14
Health needs only & / or social & other needs	*so it must be relevant to DN if its a social job *DN confined to giving insulin injection only because of pt (schiz) which makes him difficult to get to know, Dn apprehensive *health and social	p2 p5 p14
Ideal vs reality	*pt view vs dN view *DNs mop up consequences of early discharge (no physio for total knee replacement) *constraned by ability to ask about socially unacceptable questions (elder abuse) *social vs health needs *You have all these demands made on you, and not feel that you're equipped at all to deal with them, and how people demand things from you	p3 p7 p12 p6 p17

Specialist nursing General Nursing Core community needs assessment	*staff nurses don't do any assessments, its the sisters role	p17
Purpose:		
Outcomes	*DN has giving sucked out of her, bit by bit	p17
Assessment for what ?	*To follow up, to see if something can be done *To instigate home help *Don't talk to service managers when service deficit identified because don't see it as a route to change *to give to patients	p1 p2 p7 p17

Characteristics:	Comment:	Page no.:
ELDNKY03 A single event & / or an ongoing process	*Records used for planning of future services	p2
	*use of agency social care=>different people each day, change to care package (better continuity) =>better QOC	p3
	*changing situation-continuous assessment	p3
	*ongoing "while I was waiting with her, the neighbour turned up & I got more of a picture	p4
	*snapshot assessment of pt view of need wouldn't necessarily be relevant as not ongoing	p11
	*continuity =>relationship=>people telling you things	p12
	*continuity means missed / hidden things become apparent. One off visit not easy to find out all info	p13
	*ongoing	p19,20
A structured or a non-structured undertaking	*1yr down road more understanding about role in care planning meeting	p2
	*assessment as an ad hoc thing c.f. model based assessment, becauseof time	p7
	*assessment document structured by Roper included social care, which needed updating, so change in progress	p9
	*changed ass document lacked structure / philosophy - lengthy and inappropriate	p10
	*structures fine, it was just disorganised	p11
	*structured	p19
	*structured by first visits - DN needed; or if not seen for a while - monitoring	p21
Professionally owned / social service led	*Joint meetings	p1
	*SS take over asessment, DN find not always appropriate + exemplar	p1-2
	*DN have to do own assess	p2
	*if care package needs changing, has to go before SS panel with nursing assesst document where decision is made. SWs reluctant to do this d.t. budget & panel red-tape (inc. workload) considerations	p17
Health needs only & / or social & other needs	*ambiguity d.t. changing defn of health and social needs	p6
	*if get people up, doing something personal, it can be a great tool to assess/ monitor(exemplar)	p13

Ideal vs reality	*agency care=lack of continuity *lack of time => assessment ad hoc *lack of time =>missed meeting in hosp prior to discharge=>missed opportunity for preventive care *difficult to meet /address needs in pts preferred way	p3 p7 p7 p16
Specialist nursing General Nursing Core community needs assessment	*Everyone assesses from variety of profs, even auxiliaries, but at different levels - DN needed for 1st assess and until she feels that assesment is complete	p19 p21
Purpose:		
Outcomes	*continuous assessment =>relationship=>better outcomes (exemplar medication) *safety, comfort	p15 p18
Assessment for what ?	*checking pt condition (sometimes intermittently with SS care) and checking whether SS services are being provided *to identify where further services are necessary (egcare unit,hosp) or appropriate *to increase QOL for pts	p3, p18 p3, p16 p16

Characteristics:	**Comment:**	**Page no.:**
ELDNKY04 A single event & / or an ongoing process	*monitoring pt condition	p1
	*continuous to get all info., but try to do as much as possile in 1st visit as don't know when will get back	p3 p8-9
	*more than 1 visit, but experience has taught this, as used to try & do everything in first visit, even though in theory knew this wasn't possible	
	*contiuous	p12
A structured or a non-structured undertaking	*models are differently used for different people so not rigid	p7
	*documentation used flexibly - to keep people on track but not to dominate	p7
	*between structured & non-structured(an idea, but non-structured	p12
Professionally owned / social service led		
Health needs only & / or social & other needs	*social & health (exemplar p2)	p1,p2,p13
	*relationship too	p10
	*psycholog care constrained by time	p10
	*if SS do social care DNs can do psychological	p11
	*DN=client led;SS=resource led	p11
Ideal vs reality	*hard to meet all needs	p1
	*lack of resources makes DN address social needs	p2
	*missed information re needs d.t. specific nature of needs addressed by joint assesst.	p3
	*false defns of health & social care=>quibling about who will do job	p5
	*sometimes above=>reassessment of amount carer does=> ? more/ having less flexibility if SS brought in	p10
Specialist nursing General Nursing Core community needs assessment		
Purpose:		
Outcomes	*shared care for pt SS-DN	p5
	*to meet needs	p10

Assessment for what ?	*better quality services *monitoring *joint asst. to get SS involvement *to address concerns of staff nurses	p1 p1,p4,p8,p13 p5 p13

Characteristics:	**Comment:**	**Page no.:**
ELHVAK01 A single event & / or an ongoing process	*not always assessing situation consciously, maybe automatic	p3
	*first visit the basis for the next five years	p12
	*ongoing - come to clinic, build up trust, get round to issue (that client doesn't see as need) eventually	p20
	*child health record=ongoing & encourages parental involvement	p21
	*very difficult to know how in the long term its (CHRs) going to work out	p22
	*single one-off event	p37
A structured or a non-structured undertaking	*just a chat, automatic	p3
	*sometimes contact is structured by routine visits, sometimes by individual circumstances	p4
	*documentation structures to an extent, but still indiv. HV differences in how it is used=prof. judgement	p6
	*structured by standards (altho' can't specify precisely what they are)	p13
	*first visit can be structured by CHR	p21
	*structured by knowledge of child development & theory	p23
	*structure defined by prof.judgement	p36-37
Professionally owned / social service led	*professional judgement under question	p6
	*prof judgement structures visit	p36-37
	*HV essential	p37
Health needs only & / or social & other needs	*social visits as requested by client, just for a chat	p3
	*whatever social circumstances I would be the same	p13
Ideal vs reality	*if client accesses HV=priority, ideally ?shouldn't be so	p4
	*feel as if should be doing more in assessment	p9
	*time constrains joint asssessment and working	p9
	*client doesn't want something done about sleep problems	p23
Specialist nursing General Nursing Core community needs assessment		

Purpose:		
Outcomes	*nothing HV can do about noisy neighbours except listen & write letter if wanted	p14
	*continued relationship so that potential for addressing problem (if blocked by family) is there (exemplar: housing not main problem)	p15
	*client decision	p23
	*Client realises HV can't help them	p28
Assessment for what ?	*monitoring	p8
	*relating circumstances of situation (family etc) to lifestyle	p12
	*encourage to use facilities of clinic (weighing devep checks, immunisation, post natal group)	p12
	*to identify where support is necessary	p14
	*referring on	p23

Characteristics:	**Comment:**	**Page no.:**
ELHVAK02 A single event & / or an ongoing process	*today was literally just an assessment, "shes got a lot of needs that need to be met before we can build up a relationship to get anywhere" *ongoing	2 3,5,p9
A structured or a non-structured undertaking	*structured by needs assessment at a community level *structured by documentation, with some flexibility / informality *structured by standards *structured by HV, but flexibility needed for client interjection	p2 p3,p10 p18 p21
Professionally owned / social service led		
Health needs only & / or social & other needs	*community needs dictated moved time of clinic *more than childs health mothers as well *health and social needs assessment are totally separate *corporate meetings allocate who is doing what *health & social needs (social problems more subjective)	p1 p4 p6 p8 p22
Ideal vs reality	*ideal is to record everything CHRs, family record etc, but reality is that content of doorhandle visits don't lend themselves to good record keeping *clinic held family record go against philosophy of CHRs *CHRs not assessment of need, record of dvpt & action; clinic record is more so *resources don't allow NA to be completely client led,although evidence of needs being identified anyway (exemplar)	p5 p5 p9 21
Specialist nursing General Nursing Core community needs assessment	*HVessential	p21
Purpose:		

Outcomes	*record child development & overall health *long waits after referral, du to lack of resources	p4 p14
Assessment for what ?	*to try to address major needs, then build up relationship, then gain trust then other needs *meet clients needs, then relationship, then the one you perceive as a need *liaising, referring, corordinating,detection of and ? diagnosis of special needs *to provide high QOC, according to resource provision (mission statement) *to help client overcome problems *to give encouragement where problems are overcome	p3 p9 p14 p17 p22 p22

Characteristics:	Comment:	Page no.:
ELHVAK03 A single event & / or an ongoing process	*more than one visit describing process of new birth follow up visits *	p14
A structured or a non-structured undertaking	*something we do subconsciously, not using a checklist	p1
	*very individualised some questons to some clients butnot to others	p1
	*guided by theoretical structures	p1
	*flexibility if unstructured	p1-2
	*house then family, then mum	p2
	context-local environment, house,family,feedback to HV input, knowledge, background info. needs	p3 (2 x exemplars)
	-family ,context emotions, babys health	p4
	-environment(housing), physical self care, finances, emotions, family context	p5
	THEN DESCRIBES ROBERTSONS HV MANUAL WHICH COVERS SIMILAR AREAS WHICH SHE USES IN HER PRACTICE	P11
	*structured partially by CHR (parental record less well recognised)	p12
	*relationship centred	14
	*non-structured records difficult to distill essence of visit	p17
	*try very hard not to allow service provision to strucutre defn of need	p21,p22
	*structured by type of visit - clinic, client demand/urgency, new birth visits, developmental checks	p26
Professionally owned / social service led	*NA by HV -responsible for client wholly, no-one looking over your shoulder	p17
Health needs only & / or social & other needs	*	
Ideal vs reality	*CHRs -parent records cause dilemmas on how to record familial needs & their progress; also honesty becomes problematic with client if parallel records are kept	p12 p12

Specialist nursing General Nursing Core community needs assessment	*special needs centre core community assessment- everyone inc. parents gets copy	p9
Purpose:		
Outcomes	*need not always met d.t. family situation (head lice) or lack of resources *In above laterr case have to make do	p19 20 20
Assessment for what ?	*give information to client *to discuss issues *to identify areas need reassurance *to identify developmental delay	p3 p3 p4 p8

Characteristics:	Comment:	DN/HV
a) A single event & / or b) an ongoing process c)muddled		a)joint visit DN1 b) DN1, DN2,DN3,DN4 (try to do asmuch as poss 1st visit n.k.when return),HV3 c)HV1 equates addressing Needs with NAHV2 ongoing but s.a. HV1
a) A structured or a b)non-structured undertaking c) mixed		a)HV1, but flexible b)HV3, but S by theory c)DN1,DN2,DN3, DN4,HV1
a) Professionally owned / b) social service led c) Joint		a)wound care DN2;HV1, but under challenge;HV3 b)DN3 c)DN1, DN3
a) Health needs only b) social & other needs c) Health & social		a) b) c)DN1, with limits; DN2, except if pt want health only; DN3, should be but ambiguity d.t. changes; DN4, withacceptance that if SS do social frees DN time for psychol.care;HV1; HV2 NA totally separate, but HV does both H&S;

Ideal vs reality	resources (time provision petrol,wait for referrals => action)	DN1,DN2,DN3, DN4,HV1,HV2
	different perceptions of need	DN2,DN3,DN4, HV1
	skill	DN2,?HV1??
	lack of continuity d.t. agency care	DN3
	Joint assess=>missed info.d.t. specific nature of NA	DN4
	CHRs not asst of need	HV2
	CHRs vs family record (clinic)	HV2,HV3
a) Specialist nursing b) General Nursing c) Core community needs assessment d) mixed above		a)DN2,HV2 b) c)HV3 special needs only d)DN1,DN3
Purpose:		
Outcomes a)referrals b)DN worn out c)better care/meet needs d)shared care e)none f)continued relationship g)client decision h)Client realises HV can't help i)Record of CH dev. j)long wait k)making do		a)DN1,HV2 b)DN2 c) DN3,DN4 d)DN4 e)HV1,HV3 f)HV1 G)HV1 h)HV1 i) HV2 j)HV2 k)HV3

Assessment for what ? a)monitoring b)DN/HV addresses need c)further investigation /referral d) to identify where DN cannot meet need e)Better QOL f)Better QOC g)to address conerns of CSNs h)Encourage use of facilities		a)DN1, DN2,DN3 (pts &SS),DN4,HV1,HV2,HV3 dev delay b)DN1,DN2,HV2,HV3 c)DN1,DN2,DN3(SS),DN4 (SS),HV1,HV2 d)DN1,DN3 e)DN3 f)DN4,HV1,HV2 g)DN4 h)HV1

APPENDIX 6L3: SUMMARY
Individual & Family Unit Assessment

Individual & family / unit assessment dimensions & skills:	Comments:	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page
Clients within the context of family	a) Incorporates in approach to NA	a1 a3	a1,2, a9- a10, a13*	a5	a1,2, a3	a1, a12	a1	a1
	b) structure of Family	b1			b8	b4,8		b3,4
	c) Different members of F present affect assessment	c1			c10			c4,5 c6
	d) mum / F an assessor too	d3		d5				
	e)even absent family affects pt need		e3	e16 e17				
	f)assess F resources to assess need (continuously DN2)		f6, f10			f37	f17	f13 f2
	g)Family giving care	g4	g11 g12 g14	g5 g16 g17	g1	g8	f17	g6
	h)relationships within F can cause vulnerability / affect need for service		h2, h10 h12-13	h5	h10	h15	h4	h6
Who is the client ?	a)esp during joint assessment SS-DN	a2			a2			
	b)F anxiety can sway DN assessment	b3						
	c) justify inv. in family social needs in terms of child health	c3						
	d)client=family					d11-12	d1,2	d3
Family & carer NA	a)F needs to adjust to pt illness	a3	a14					
	b)family needs to maintain privacy from outsiders	b2	b13					
	c)parental inability to care results in child need (mum disabled,son needs care-DN3)(poor parenting skills, ch needs careHV1,HV2)				c3	c8	c17	
	d)strength of relationships		d2, d10 d12-13	d5	d10	d15		d4-5
	e)ability to care					e8	e17	
	f)family tree "learned upbringing"					f8		
	g)first visit really important as basis for your whole next 5 yrs (HV1)					g12		

Conflicts of interest	a) F needs can mean pt/child is not assessed fully b) addressing F . needs can mean childs needs are not addressed fully (Food-chemo) c)carer needs (for independence DN2, housing DN2, respectability DN2,work DN4, for active care,DN4 disability,HV2,memory loss) conflicts with Pt, d) F needs=pts needs perceptions of n, actual n, (often DN4) e)change to F circumstances=pt need f)PR vs CHR ethical dilemma g)use of F as interpreters can cause conflict in HV(ethical & practical)	a3 b3	a12 b12 c2 c12	d11	b10 c10 c2 c3 d1	b23 e28	b17 c17 c22 b17 f4,5	b20 b21 c20 c21 e12-13 f12 g4-6
Eliciting the diversity of human responses & perceptions	a) listen (also for emotional support) HV2 b)negotiate & reason with SS (pt advocate),pt c) tact with F in case provision not made d)involve F & C in actual care to reduce anxiety e)teach F &pt about care f) reorient pt re:need g)observe h)question i)need for more DN educn. before can bring up areas for HP j)experience k)be "laid back" (non-judgemental HV2) & wait for relationship to develop l)encourage communication also outside HV relationship ie to housing) m)honesty=>trust n)give info. o)records	a1 b2 c2 d4 f4 n2	b3 f3 g10 n2	a14 b15 e12 e13f g15 h11 i22 n14	a1 b1 g7, g8* h7 k1	a13 a23 g5 g12 g23 h23 j)?5 k12 l23 m29 n29	a3, a14 b15 b16 e17 f3, f17 g3 h3 k17 k3 k10 l10 l15 m10 m17 n4, n16 o4	a21 g14 j10 k14 l14 m21 n9, n19 n21 o12

Specific skills to measure & record indicators of need (technical ability)								
Specific knowledge of underlying biology, psych etc	a)psychological control theory b)biology-pathology c)psychiatry dpharmacology e)developmental	a4	b9	b15 c14 d15	a3 b4,8	e: not present	b10 c4 e3 e10	
Negative examples / missed opportunities	a)F=pt perception of need b)missed opportunity for indiv.pt care (physio & rehabDN3;HV3 washing hair for nits) c) Health promotion, "unless it comes up" d) to communicate e)to be honest			a11 b18 c22	a1			b19 d4-6 e21
I'm in the front line Family calls me:	a)when C condition changes	a4						

APPENDIX 6L4: SUMMARY
Collective Needs Assessment

Dimensions & Skills	Comment	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page
Compilation & analysis of health needs data in profile	a) student profile HV3 too much info, can't retainit b)caseload profile		a1		a4	a1 a31	b1	a19
Different levels of "profile" GP practice, Trust, Caseload etc	a) caseload vaguely profiled /organised in terms of new referrals / health needs b) intuitive profile of caseload didn't tally with statistics c) caseload "profiled" only in terms of number of visits needed by each client & clients of worry to DN d) caseload profiled largely intuitively d.t. lack of time e) caseload profiled fully for management f) caseload profiled incompletely-by case counts particularly child protection & children under 5	a1-2	b1-2	c20		d2 d26, d30	e1-2	f23

"Intuitive" profiles: uses & limitations	a) provision in community for social needs of sick children not present b) local knowledge allows for getting client in through back door / cuts red tape c) No increased provision in community for acute care of children in response to. increase in hosp discharge d) Notoriously unsavoury area e) Intuitive profile not sufficient because continuously changes: need central info. line f) DN/HV essential with knowledge of community procedures / provision g) what saw in area contradicted statistics h) Intuitive caseload profile used to organise workload i) recognise from intuitive caseload profile that people seeing might not reflect community profile needs j) walk the patch , put yourself in their place k)special needs l) support for mums with twins	a1 b1 c1 d1 e1 f1	g1 h14	i21		j25 k30		l21
Wider purpose of Individual NA & ability to generalise from the particular	a) If indiv need frequently occurred, discuss with colleagues		a1x2					

Purpose & use to which community profiles are put sythesising info. for service managers & planners	a)If saw need in community go & see manager to see what could be done b)records of activity & assessment goes towards future planning of services c)profile of community contextualises need d) HV1 no feedback from managers about whether seeing right people e) statistics used to get value for money f) caseload profile used by manager to "justify" HVing to GP g) used by HV to justify new clinic to manager h) keep going to management, about service need, but not responding		a1 c2	b2	c1	b2, b5 d2 e6	b19 f2 g2 g19	h22-23
Rhetoric & Theory vs Reality	a) profiling community is fine except DNs only get pts through referral not search for health needs b) practice of searching for needs as DN is difficult			a21 b22				
					only 1 eg			

APPENDIX 6L5: SUMMARY
Working & Sharing with Clients

		DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page
Client led assessment:seeking their views	a)seeking their views as a mode of working (including pt time of visit) (pt is expert in conditionDN4)	a1	a9	a14	a1,a5 a11	a4	a2	a9
	b) dependent on relationship	b1			b1-2	b20		
	c) promoting care by family /client	c1,2	c6	c15	c1	c21		
	d) F want assessment = priority; HV2 need therefore more defined by client	d2				d4	d17`	
	e)dependant on observation, listening & facilitating expression of need	e3						
	f)give background info. so that pt can work it out / compromise can be met (moving pt view towards prof view of need) (HV1 client then has sense of achievement)(HV2 client uses HV for access to other services)		f3,4, f10	f14 f15 f19		f16 f20 f23 f24	f3-4 f18	f14 f20
	g)"try this & see, if don't like it...."		g3	g14				
	h) be honest if pt view is detrimental to them , but abide by their decision		h4	h19				
	i)be honest if pt view results in higher need for service, but abide by their decision		i5 i11		i1			
	j)If pt view of requirement from service does not = SP, listen but do nothing		j8					
	k)If pt view of requirement from service does not = SP, listen but try to do something				k11	k15		
	l) be honest if F view of need inappropriate for child (Ch abuse)					l20		
	m)Included in mission statement					m29		
Advocating for clients	a) for care from SS	a1			a2			

Client held records	a)CHRs more client centred					a21		
	b)CHRs difficult to keep for doorhandle visits					b5		
	c)CHRs vs FRs					c5		c12
	d)CHRs not always kept by parents					d5		d13
	e)CHRs not multi-disciplinary friendly					e6		
Theory Vs. Reality	a) Dn/HV is "in the middle" between managers / professionals & pts	a1	a7 a15		a?in ob		a15	
	b)family vs individual care-difficult to assess & address both needs : whose needs are uppermost ?	b1				b20		
	c) client vs professional perception of need & priorities (HV1 partic. difficult when you are a student)	c1,c2	c3		c1	c32		c24
	d) Pt refusal from DN service, abide by it, (DN2 but managers /fellow DNs unhappy =>educational need for SDN & CPT;DN3 informed GP & documented it)		d15	d15				
	e)pt medicn. pt refused, but DN made take 1 of tablets due (Captopril)		e15					
	f)pt refusal of residential accom despite being high risk of falling. Dn abides pt decis.			f19				
	g)Getting info. for clients can take time					g25		
	h)child abuse has to be prof. led assessment					h20		
	i)lack of clarity about HV role makes this difficult							i9
	j)Social stigma attached to situation coupled with poor HV-client relationship makes it difficult for HV to be honest							j19-j20

APPENDIX 6L6: SUMMARY

Joint / Collaborative working.

		DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page
With colleagues in own discipline	a)DNs assess in less detail	a2						
	b)Different DNs useful with pts for assessment & care (as have different skills & develop different relationships with pts)		b3b 5			b37	b1,3	
	c) skill mix frees up DN / HV resources					c11b		
	d) skill mix -DNs only do assessment		d17			c27		
	e) Takes a while to get accepted into team		e17				e18	
	f) DNs /HVs all think differently therefore decision making / standard setting / working as team difficult			f6 f9		f7		f26
	g)skill mix: CPTs used as agents of change in methods of working			g10				
	h)Different DNs unhelpful in pt care as philosophy of working against own			h14 h17				
	i)Need other assessors outside DNing too			i19				
	j)CSNs useful as experienced,(DN3&4 act as another assessor)			j21	j4 j9 j13	j11		
	k)Hvs work as a team:college work on teams helped					k10		
With colleagues in PHCT	a) Daunting (DN2 because of lack in confidence)		a5-6					
	b)Give info. re pt progress to GP / GP as gatekeeper		b9 b13					
	c)Sharing CSN between HV/DN not helpful					b11		
	c)Resources short						c14	

With Social Services	a) Resources short	a1,2		a17	a2,5			
	b)Difficult to speak to person resp. for care	b1						
	c) Need for different assessments (not necessarily SSother agencies too) since differences in perspective eg. DN1 HV2 child protection;DN3 medication needs: multi-assessment useful	c1		c1-2 c20	c8 c9	c37	c3 c17 c22	
	d)don't abuse services, but can't get help from them when needed	d2						
	e)SS/HS split unhelpful in trying to monitor pt situation (eg DN3 HH; HV1,2,3not sharing record -CHRs)	e2	e6 g6	e13		e21	e6	e13
	f)F-F meetings help re:clients & issues (needs improving DN&HV)	f2		f6	f10	f10	f6 f8	
	g)Social / health split unhelpful in assessing for provision	g2		g6 g5 g13 g17	g2 g5			
	h)DN stuck in middle	h2			h5			
	i)need to be assertive, negotiating & reasoning as pt advocate	i2	i6		i2	i11		
	j)SS resistant to change, suggestions & ideas	j2	j6-7					
	k)Evolution of change / transition (DN2&3 HH ->personal care;DN4 joint planning meetings;HV2 &3 joint assessment / planning meetings not well established practice)		k6	k2,k3	k2-3 k3		k7-8 k10	k8-9
	l)DN / HV central liaising agent to team			l6				
	m)depends on knowledge of SS				m9			

With other agencies	a)Works closely with hosp. consultant used as expert	a1						
	b)depends on detailed knowledge of whats available	b1	b12					
	c)advocacy (DN1police)	c3						
	d) Chemist very helpful		d5					
	e)hosp discharge without informing DN of care package			e4, e7				
	f)Resources short (housing, equipment)					f14 f28	f14	
	g)meetings helpful, but difficult to get together					g15 g16		
	h)education reluctant to share info.					g17	h7	
	i)No-one person responsible for "tieing it together"						i7	
Supervision Issues	a) Supervision / guidance /second opinion given by medical profession	a1	a4	a15	a8			
	b) Measuring up /refining own assessment, care & professional activity by reference to others, not necessarily (but usually) of own discipline. Where established mode of practice these were chosen for the DNs HVs. (consultant,DNs, GP,HVs;) These were very valued (HV3 encouragement & support & learning) except where mentorship relationship was not good.	b1	b1,4 c2 d15 e16	b9	b8	b6 b26 b34 d32		b24 b25
	c)More senior DNs protect you from worst cases			f10				
	d) Supervision by DN /HV depends on good relationship, which was missing in cases cited opposite						g13	
	e) mentors need teaching too							
	f) continuing education needs in part addressed by CPTs / mentors; but need to have close contact to benefit							f25
	g)continuing education joint multi-disciplinary training in Trust							

Referrals	a) Waiting time long - what to do in interim period b)Knowing services means can cut thru' red tape c)Prevents overloading or unacceptably high levels of care d)For expert led care e)cuts out unnecessary assessment f) see pt after hosp discharge you are main referral agent g)purely for service h)need info. back re:action i)GP referrals seen faster than nursing /HVing by other agencies	a1 b1 c1 d1 e1 f4	c10 g2		a)5	a8 d9 g8 h9	a14 h8 i8	d4,8
Care packages & continuous assessment	a)Instance where care package needed to evolve as pt situation changed as pt adapted to home after hosp stay b) knowledge & communication between players poor when pt situation changed rapidly leading to a HH service omission c)meetings prior to discharge /prior to residential care / respite /social services involvement helpful in designing care package. DN4 These cause anxiety re:outcome & process of meeting)			a)4 b4 c7 c16 c18	c3			
Info. source re others involvement: keeping abreast of changes / action	a)Patient / Client /relative central to team,eg SS-housing b)Can get a lot from looking at pt environment c) Relative central to team assessment d) don't always know of others involvement	a3	b10	c5	d11	a9	a14	

APPENDIX 6L7: SUMMARY
Knowledge & Provision of Service Responses.

		DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page
Formal service provision (NHS, SS, Education.	a)SS network for children with disabilities	a1						
	b)Presence or absence & waiting times for service	b1	b6		b2	b9	b8	
	c)Temporary rehousing difficult to arrange	c1						
	d)Managing technical work (asept dressing) in pts homeoften less than ideal	d2						
	e) Knowledge of back up services essential to role (pathology, specimen transport, immunisations)	e2	e4			e11		
	f) Standard setting in Paediatric CNing & supervision informal	f1						
	g)Other profs (particularly hosp) knowing of PCNing /HVing service practice & restraints, particularly for referrals	g2	g4				g2	
	h)Aids and equipment from OTs/hosp	h2			h9	h17		
	i)Hospital procedures and provision		i4			i17		
	j)Local as opposed to national provision		j5	j11		j11	j2 j13	
	k)SS criteria / rules for inclusion into care(DN2); knowledge of changes to SSSP (DN3p18); knowledge of people in SS (DN3,4)		k6	k16-17 k18 k3, k4	k2,5			
	l) Own discipline criterion for care & changes to		l6		l9 l13	l5, l11 l30		
	m) Normal prof practice & procedures (Dn2 in difficult cases ; HV1:caseload management issues)		m15			m29 m30		m26
	n)knowledge of care package for particular pts			n4	n2			
	o)knowledge comes from experience (previous &as Dn HV) & trial (& (HV3 from other HVs)			o15	o9	o24		o18
	p)Educational service standards / plan for children w special needs						p15	

Informal services (voluntary, neighbourhood, private, commercial)	a)Informal counselling, services, financial help or information about illness run by families changes so frequently: need central info. point	a1						
	b)Evidence that DN/HV knowledge is patchy, (HV1 despite provision in training for learning)	b1	b11-12	b15	b9	b24 b25	b13	
Gaps in provision of resources	a) Social gathering places (day centres /play centres , support groups etc) for those who are sick or have special needs, as can't go to many places within community as not specialised	a1	a12				a16	a20 a21
	b)Not enough resources, therefore wait before action is taken (particularly referrals are picked up)	b1	b6		b2	b9 b26	b8	
	c) Care during holiday periods by Paediatric community nurses	c1						
	d)Hosp follow up for anticoagulant Rx		d4					
	e)Rehab follow up (DN2 physio;DN3 general) & consequent deterioration in pt condition / pt anger-> higher demand on DNs		e7	e17				
	f)Need central info. point with details of service, as own knowledge patchy, (HV3 also if info collated could be used to pressure for more resources via media	f1	f11-12			*(f26 ??)*	f13-14	f22
	g) Transport to disability centre not provided						g14	
	h) educational psychology for children w special needs						h16	
	i) Interpreting service short on resources							i6

Ethical Issues in meeting needs	a) Pass the patient SS<-> DNs / HVs; or circumvent queuing system by HV->GP->SS b)nurses could do a better job than SS ie rehab c) HVtime spent searching for service vs possibility that no service exists (prioritising time) d) to get place in nursery for special needs have to be "at risk", yet families under stress dont classify as such - HV2"its always got to happen before they do anything". e) Interpreting by families f) Use of student Hvs to plug resource gap - not discussed as ethical issue though		a6	b17	a9		a8 c14 d16	e6 f22

APPENDIX 6L8: SUMMARY
CC Act & Political Issues.

		DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page
Knowledge of the Act & impact on working practice locally	a) erroneous (people coming out of hosp quicker, priority groups for care, hospital base assessment as lead)	a1	a7		a4	a16-17	a6	a7
	b)pt led			b5				b10
	c)SS-HS redefinition of care			c5				
	d)Improved liaison between HS-SS			d5			d7	
	e)linked directly to NA & SS-HS split				e1			
	f)Role changes associated with standard setting					f7		
	g)Education Act & Children Act: statementing children						g7	
	h) GP fundholding-> more power for GPs						h8	
	i) Belief that DNs work is more affected by Act "Idon't feel that we are so involved in the CC Act"							i7
Structural / Organizational issues & sequelae	a)Talks of bureaucracy of SS / HS divide and resource issues, but unable to link to Act	a2	b6					
	b)Social - health need discussed as difficult distinction	b2	b6	b6				
	c)Talks of bureaucracy of SS / HS divide and resource issues, & is able to link to Act			c5				
	d)Talks of fact that there is no joint documentation (HS-SS) locally & practice in joint working is still informal			d5-6				
	e) Purchaser / Provider split - requirement for info re working practice HV2"They justify HVs and what they actually do. I don't think a lot of them actually know"HV2 info useful as bargaining tool					e5	e2 e2 e19	e7 (mentioned only)

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Funding issues & Ethical implications	a) Budget issues re: health & Social split - DN1:"if they can possibly kick it over as a health need, then they can save themselves some money" & associated frustration b) SS charging for HH service: can pts afford it influences decision to refer by DN c)discusses defn. of need and theory at college, based on different types of assessment, but says"you know, at the moment I've never had any time to do any of those things. I'm struggling to do what I'm doing" d)nurses can do better job than SS e) HV2"Its a money based service unfortunately...you have to fight & I have to put the bullet in my clients mouth and say well write to your MP"	a2	b2	a17 c7 d17	a5		e15	
Decision making & prioritising	a) Based on negotiation between H & SS b)prioritising in HS-SS decision by persistence of DN c) Decision to refer pt affected by financial concerns	a2 b2	c2					
Theory & Practice	a) Waiting b) Evidence that Mission statement / service philosophy does not affect practice (either N/K or openly stated as such)HV1"I'd like to thing that I was providing a good service...regardless of what their particular philosophy was" (weak evidence that its used to measure up own practice) c) Using Education Authority document containing standards /mission statement to ensure a clients service is improved	a2 b11	a6 b14	b20	b13	b30 c15	b17	b26

College preparation about the Act	a) Looked at development of CC in history, stopping short of Act...DN1: "it was like a big yawning gap really" DN1 "lectures we had were very muddly" & DN2 can discuss CC devpts but not Act; HV1 "nothing really constructive" HV3"I was disappointed with the information that we were actually given" b) Students precipitated small group discussions containing short overview of Act with course leader as no teaching re Act. c)pt led service not associated with Act, but Dn4 said "No, its only... I was doing, sort of the CC Act, I mean I would have done it even if they hadn't been around"	a1 b1	a7		a4 c5	a19		a7

APPENDIX 6L9: SUMMARY
Educational Issues:Content

		DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page
Health Policy	a)NHS & CC Act b)Children Act needed expanding c)Education Act:HV3 "no I'm afraid not" SEE CC ACT SUMMARY, plus DN2"whether my position was important enough ...for that to have any meaning"(p7) HV1 re:joint working "all I can remeber is some great big list about all different types of people & agencies & needs & things but nothing really constructive" p19							b9 c10
Needs theory	a)Holism b)Bradshaw / Perception of needs (DN2,recognise name only;DN4 &HV1,HV2 can talk about perception of needHV3 came up in other course not HV training) c)Family care d)Needs generally discussed e)at a community level f)Sociology:meet basic needs first before addressing other needs	a1 c1	b8 c7 d8		b6 e6	b19-20 c34 e1	b3 f9	b10 d10

Needs Assessment	a) Models (DN3 had a great deal of trouble with models) b)Use of Forms / Record Keeping "nonedescript" use of black pens etc, but not abutobjective note keeping c)Methods of (eg family tree) d)communication skills e) should have more child develpt & assessment training HV3 says what was there was helpful peer teaching in class f) liaison with other agencies / discipines stressed in course g)HV studies not helped, (although HV2 says interesting HV3 says it "wasn't interesting.. I'm afraid its not sticking in my mind" h)Robsertsons framework used as simpler than Luker & Orr, but from own instigation not from course- should be in there i)Peer support helped by discussion of issues cases informally "	a1 d2	a16 d5	a7 a22 c7 d22	a6	d5 e6	f9 g10	b16 -17 \ e16 h11 i16
Other	a)Evidence that difficulty in using theory or translating it (DN3) into practice DN1"But I just don't think it [UEL classroom learning +CPT] prepares you fully for the reality"DN2 "I think its important that educators get a realistic perspective of what is actually useful" HV3 "tutors could be a little moe realistic" Do you think that you were adequately prepared for practice DN4 "I think so, I think you also learn a lot through experience as well" also HV1 "its different when you get out there & do it yourself isn't it on your own" HV2 need teaching on practicalities of how to use of profiles to reorientate care HV3 "no b)CPT acts as model, (learn about practical things DN1;"bread & butter stuff" HV2)(DN3 CPT not appreciated for inflexibility & "going on at me about theory all day") /Learning for DNing done n practice	a2 b3 c3	a5 a8 d6 d15 d17	a21 a22 b11	a14 b14	a34	a2 b20	a10 a27

Content not tailored to individuals PEL or applied to each discipline	a)DN1 - no community exp. =>mismatch which was met in part by 1 tutor, teaching structure of community care services would have been appreciated / class size too big b)Not applied to discipline	a1-2		b22	a15	a11		
Quality	a)"I found many of the lectures of poor quality" also said that students knew more than tutors on occasions (DN4 pointed out that CC act session taken by a trainee lecturer & was poor; HV1 said "nobody really understood it" p18, although DN4 enjoyed lectures where specialists came in and spoke well HV2 sociology, health visiting human rights studies & HP helpful rest "not really at all"			a22-24	a4 a14		a11	
	DN3 believes that DN training should not lead to Sister status, should be dependent on experience			p25				

APPENDIX 6L10: SUMMARY
Educational Issues: Process

		DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page
Classroom Learning	a)Compromise between student with pre-community exp. and those with none or between different disciplines	a1						a7
	b)Groupwork were groups purposefully mixed helpful as learning from peer group DN1 directly relates this to her DN student practice showing it increased understanding of practice of assessment; DN4 record keeping & asessment forms HV3 says this was most helpful thing about course wrt NA				b14		b11 b12 b13	b15 b16
	c)Need more on the process of assessment of pts (not paper exercise) in groups		c16					c27
	d) No note taking re:assessment in lecture notes, but DN2"I'm sure I can remember going through it quite well ...when we were doing nursing models, I think".."to have the notes in your file to go back to is useful, but.."		d16-17					
	e)Student teacher took sessionon NHS & CC Act which"wasn't very well taught"			e5	e14			
	f)Groupwork in research methods for critique left student feeling that "you can make research say a lot of different things"=> wary [my inference= teaching feedback poor], but later said research methods made DN3 think of things in a different way, she had answers for you, but sometimes made you find out which was "very good" HV1 was able to use this and see rules for interpreting research			f8 f22			f13	
	g)HP need more training to translate theory into practice			g22				
	h)Recognition that although the content of the course might not be relevant to practice, "Whether the ..process & the discipline of making myself do that has helped me, I couldn't say really...well yes it did change me actually			h22				
	i)Large class of mixed disciplines unhelpful"			i22 i2	i14			i7
	j)Good teaching leads to answers either self derived or from teacher DN4 no answers lead to "muddle"			j23	j4 j14			
	k)Good teaching makes you think about what you're doing, but not necess remember details ie DN4Bradshaw				k6			
	l)NA DN4"you heard it all the time at university & I suppose that in itself made me think about it when you are outin the practical setting"; but more structure needed				l14			
	m)Coursework guidelines poor for case study					m36		
	n)clasroom itself unhelpful as poor environment							n7

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Informal Course Learning	a) Evidence that students initiated additional teaching support. DN1"but didn't really cover it in too much depth" b)Too much expected of the course co-ordinator who "was very stretched" c) Sent out to investigate area by course - good method	a1	a5	b23		a18 c24-25		c18-19
Practical Nursing / Health Visiting in Community / Community Practice Teaching	a)CPT acts as model, b)practice prepares you more for reality c) Would have liked more DN practice in course, accomodated by better structuring of course thru' week Would have liked more bridging of theiry practice gap in college d)CPT need more info / teaching re: course standards & content e)Course should be more service based (DN2 formerly SEN) f)CPT relationship poor DN2 felt "hostility" p16 "I think I was trying so much to survive as a person that I was missing a lot as a nurse" tutor support present, but CPT not changed DN3 CPT inflexible DN4 No CPT on supervised practice just mentor HV1:CPT knowledge poor HV3 didn't get on g)"the college needs to work with us" to initiate change in practice not just students but in qualified staff via individual & groupwork h)DN3 "College had far more responsibility to make sure that the CPTs were offering us what we needed" i)change from areas post-qualifying difficult to get to know area, need induction	a2 b2 c2 d3	e16 f16-17	b23 d23 f10 g9 h23	a14 b4 f4	a9 f35	a20 i13	b10 b17 c10 f27-28

Prior Learning	a)Evidence that PEL not acknowledged by college b)Evidence that PEL not acknowledged by CPT c) PEL on pre-reg training more influential in practice d) PEL from midwifery training useful from theoretical standpoint	a1		a23 a25 b11	c5			d29
"On The Job" Post DN / HV Training	a) Reading / updating via research should be a recognised part of job, not just pushed on to individual b)CPTs aid continuing education by running sessions c) Supervision post qualifying essential in transition period can help confidence (HV1) d)continual learning DN3 indicates that peer learning in DN team dependent on relationship HV1 varied experiences aid learning HV3 discussion with peers helpful, particularly with service provision			a9 b10 c10 d12		c32 d34		c25 d10 d18

APPENDIX 6L: Note for summaries in Case L

The fourth health visitor in case L was observed and interviewed in the normal manner, but transcription was extremely problematic as the tape quality was inexplicably poor. For this reason, the analysis of interviews show here only totals 7 practitioners. The findings of these interviews was thoroughly checked with the audible recordings and partial transcript available for the health visitor 4, although no new insights were gained from this data.

Appendix 6M: Table 1	NEED	HV1	HV2	HV3	HV4	DN1	DN2
need as a holistic concept	encompassing different aspects				1		
	- physical, social, environmental, psychological, mental,		1	5, 7			10
	- encompassing different levels; superficial to deep		1	18			10
	- community wide to individual			1			
need as a 'virtue'	aim to visit according to need				11		
need as a single element	specific or short term need described, eg sutures					2	
need as a complex issue	as a continuing issue						
	- continuing factor through the caseload				2		
	- continuing process	11					
	as a changing state						
	- different today		10				
	- daily assessment required					5	
	- as a personal perception						9
described in relation to client - actual or example	examples - smoking; cot death, child immunisation; stresses on a particular family; woman's need for refuge, unemployment, heart disease	1	8-9	1	4 11 20		
described in the abstract, or non specifically	'picturing need', or difficult to conceptualise				20		9
	in relation to area as a whole;					2	
	- needs on caseload as whole			20	2		
	- need as public health issues				17/18		
	-						
	in relation to service provision						3

Appendix 6M: Table 1	NEED	HV1	HV2	HV3	HV4	DN1	DN2
health and social together	as an ideal		16				
	all part of a person's well being			18			
health and social needs not separate:	- never considered separating them			18			
	- hard to separate in practice (eg consider family dynamics, social network/family)	11					
health and social described together in the abstract	health and social needs/social aspect of their lives		14				
	models encompass physical, social, psychological		1				
	and environmental; mental			8			
through definition of health	'it depends on how you describe health'			18			
in examples	eg, situations of poor housing, accommodation		21		16		
	social networks and mechanisms; social isolation,	11, 7	21	10, 18			
	different cultures, interactions; social stimulation						3
needs - hidden or potential needs	seeing beyond appearances: need for awareness		7	9		6	6
	consciousness of need, unspoken by client	2		7			
	- of missing hidden need				11		
			1				
	prioritising needs: present now, or in future			2			
	looking to the future: physical health needs,		8				
	predisposing factors, 'previous history',		9, 18	10, 11			
	underlying problems, family issues, bereavement		20	12			
	background knowledge of situation					6	
	'want' viewed as adeeper level of need						10

Appendix 6M: Table 1	NEED	HV1	HV2	HV3	HV4	DN1	DN2
unpredicted or unexpected needs	examples of unpredicted needs arising	2, 6	20	10, 11	5		
	awareness of need to be 'prepared for the unexpected'; possible crisis situation				15, 16		
	awareness of skills required for unpredicted situations				16		
	'depends what comes up'			15			
client perceptions	acknowledge importance of clients perspective	1					1
	'ownership' - whose needs?		9, 18				9
	recognition of varied perceptions - client, community, professional, Trust	1		5			
specification of need in service contract	need vs want						1
	acknowledges client viewpoint	12					1
	Trust identifies need	2					
	need specified as 'figures'	1					
	emphasises quantitative aspects		15				
specific examples given of 'need', or factors contributing to it named	premature births, speech difficulty, sudden infant death syndrome, diet, iron deficiency, unemployment, dental problems/tooth decay, social stresses, post-natal depression, 'predisposing factors', heart disease	1, 8	2, 7, 9	20	2, 9, 14		

Appendix 6M: Table 2	NEEDS ASSESSMENT	HV1	HV2	HV3	HV4	DN1	DN2
targets/activities mentioned in relation to need	immunisation figures, child surveillance, development checks, physical checks		8		3, 4		
	administrative aspects carried out at assessment visit		13	9, 15		11	
level of need: individual	conceptualised as applying to one individual only - limited input required				1	2	
	awareness of need to assess individuals within family situation			10	5	6	
	avoid narrowing down to individual			12			
	records relate to individual only			10			
specific aspect of need	singled out as part of wider assessment:						
	- physical assessment, bilirubin, Mum's Hb, post-natal depression scale, child protection, labour;		8, 9, 15	4, 10, 15			
	Scriver		7				
	- remembering important single elements in complex situations		11				
assessment as a single event	distinguish short term from long term needs:						5
	short -term = single assessment						11
	short term = superficial level						11
	initial assessment:						
	overview, follow up in more detail later			16			
	thorough assessment needed to start						2

Appendix 6M: Table 2	NEEDS ASSESSMENT	HV1	HV2	HV3	HV4	DN1	DN2
level of need: family - interactions, resources, whole family system	conceptualised as a family issue; central to assessment - extended family, family support, family networks, family relationships, background relationships, cultural issues, general environment	6	2, 3, 3, 5, 7, 8, 8, 14	3, 4, 7, 9	4, 6, 6		
	conscious effort to include family members		8				
	awareness of importance of family influence; coping with family		8	9, 11, 13		6	3
	family records			9	6		
	multiple aspects at once	4		9			
level of need: caseload, area or community	caseload as a whole; area - associated with health promotion		14,	16	2	2 3	
	culture/ethnicity	7, 11					
	specific measures: Jarman		5	20			
	specific issues: chemical factory, dog dirt, roads			8			
needs assessed within a context -	recognising usual patterns in area; local family cultures; understanding 'reality'; families supported or not; family dynamics: interactions	11	8	18	6		3
	assessing environment/ knowing area; addresses; housing		7	9, 16		12	
	neighbourhood/area resources and services - available or not; neighbourhood study; need for wider than individual action				16, 20		

Appendix 6M: Table 2	NEEDS ASSESSMENT	HV1	HV2	HV3	HV4	DN1	DN2
'intuitive profile'	informal assessment at a caseload or area level	8					
	'things that come to mind' 'you are doing it subconsciously all the time . . '				2, 2		
	'identified something . . '			20			
	'you can see what people need'					23	
'intuitive assessment'	informal assessment of need at an individual or family level:						
	awareness of unspoken need	2	2, 7, 12	3, 4, 8			
	- 'picked up on', 'chatter about', 'just see how she is' 'general conversation', 'information changes place', 'just watching them' (children)			22			
	overview assessment - not at deep level			16			
	awareness of hidden needs; making opportunity for client to talk, 'just mention' issues	7		10, 11			
systematic assessment	' formal' assessment distinguished			3			
	use of models for assessment		13	7, 20			
	- Worcester models, Becker, Clark		2, 13				
	- Orem, Robinson, family tree, Becker			8/9			
	- Orem Maslow					10, 25	18
	purchaser agreement for specific assessments		13				
	assessment of area prior to planning services						1
	assessment in relation to records			10			

Table 2	NEEDS ASSESSMENT	HV1	HV2	HV3	HV4	DN1	DN2
continuing assessment	by staying in touch (phone calls, clinic)		14	17			
	several visits for detailed assessment			15, 16			
	daily assessment					5	
	initial assessment just starts relationship						2
	starts with single 'specific' (issue, or individual)	5/6	2, 7	8,9		1	
	then widens out; continues over longer time						10
profiling valued	benefits/importance acknowledged by practitioner		1	2	20		
	aware of complexity; national vs local comparison		5	21			
	basis for planning work, seeking resources			20		23	6
	has completed profile on own caseload	4	18				
	compiling profile in own time			2			
	locality manager completed practice profile					4	
	could show health promotion needs					5	
	used as systematic approach to prioritise		18				
	caseload weighting/scoring system considered		5, 18				
	need for computer system link		6				
	used for College assignment					5	
low value on systematic assessment	needs afforded low priority in area despite assessment				3		
	- traditional patterns of work continue, despite assessed needs			1			
	'getting the work done' is the priority			2	8, 17		
	- immediate needs, not long term			1			
or profiling in general	unrealistic to do community profile:						
	- time pressure; difficult to do			1, 2			
	- GPs do not want profiles				17, 24		
	records not conducive to profiling		5				
	not really thought about it yet					29	

Appendix 6M: Table 2	NEEDS ASSESSMENT	HV1	HV2	HV3	HV4	DN1	DN2
health and social divide	linked with service responsibilities in formal assessment situations, eg special needs; child protection issues; Community Care Act; elderly, mentally ill, physically disabled				7, 1		13
	health and social services have:						
	- different responsibilities			18			7
	- separate assessments						12
	linked with specific examples of social need, eg poor housing, family centre,			5	16		
	used to avoid work overload (DN)					26	
timing/resource pressure	time needed to get to know people and area				3		
	accountable for time		13		3		
	caseload and time pressure; lack of time	13	17		17, 18, 19		6
	timing assessment/questions to meet client need	5	2	10	16		
	assessment starts prior to contact		7	4		2	5

Appendix 6M: Table 3	ASSESSMENT IN THE CONTEXT OF EVERYDAY WORK	HV1	HV2	HV3	HV4	DN1	DN2
assessment requires 'getting to know'	getting to know clients and their ways						
	- takes time; several visits to 'unravel'	6, 12			3		
	- facilitated by home visits	8					
	getting to know area, caseload or services	3, 12			3, 20, 21		
	- takes time; needs experience						
	- awareness of whole caseload		21				
and 'being known'	people need to know professionals as individuals				15		
assessment as a continuing process	one visit insufficient:						
	- for assessment purposes	6, 7			5, 15,		
	- to allow response to unexpected needs				15		
	staying in touch						
	- in rapidly changing situation					6	
	- as a means of assessment		12				
	- reduces need for formal assessments		17				
	- assessment continues as long as in contact with family			16			
	ideally, would follow up all families			15			
relationship to workload	fitting assessments in with other priorities; 'juggling'; time restraints		17				3, 5
	ensure allowance for unexpected caseload pressures (case conferences etc); 'prepare for the unexpected'; pace of change		18	15			8
	skillmix team increases management role/frequency of assessments		23				

Appendix 6M: Table 3	ASSESSMENT IN THE CONTEXT OF EVERYDAY WORK	HV1	HV2	HV3	HV4	DN1	DN2
assessment as a starting point	planning						
	- follow up;				6		
	- joint planning				8		
	- for opening up issues	10		10, 11			
	- for informing clients of services		14				
	- for future needs			4, 11			
awareness of wider skills	discrimination skills:						
	-when to raise issues (eg, communicate with client, mention child protection concerns or smoking)		10	10, 13, 8	16 6		
	eliciting hidden/unexpected needs				17		
	communication skills central					16	2
relationships with colleagues	'working together' as an everyday event				10		
	- working with other team members (GP, midwife, Practice Nurse, HV, PHCT)	9		7		3	
	- liaison; updating (social services, social workers)				10	8	
relationships with clients	information sharing builds relationships				13		
	relationships central to assessment						
	openness builds relationships				13		
	less need for formal assessment if 'relationships' exist		15				
	assessment builds, or starts, relationships			3			2

Appendix 6M: Table 3	ASSESSMENT IN THE CONTEXT OF EVERYDAY WORK	HV1	HV2	HV3	HV4	DN1	DN2
questions about needs assessment answered in terms of whole work situation	without apparent consciousness, eg: in relation to 'getting to know' family; adjusting to family's needs; awareness of specific intervention or explanation; 'knowing' family prior to assessment; working with strengths, deficits, problems, giving information, to emphasise the positive apparently consciously, eg: in terms of completing records to facilitate profile	6	2, 7, 14 6	9, 10 12 4, 18	14		
role of client in assessment	- clients aware of services and what they want from them - family members facilitate assessment eg, taking child out of room interpreting (caution) - or prevent it client resources influence assessment process (eg, social support, access to telephone) - reaching agreement with families about roles in carrying out plan - accepting client viewpoint	(seen)	7 8, 17	5 9	15 6		

Appendix 6M: Table 3	ASSESSMENT IN THE CONTEXT OF EVERYDAY WORK	HV1	HV2	HV3	HV4	DN1	DN2
assessment and records	inappropriate format:						
	- individuals only			9			
	- records inhibit use of models			8		11	
	- insufficient space or detail					12	4
	- 'outdated'					11	
	changes to record format planned			22		11	4
	completing records - at assessment			15			
	- for sharing information; care planning	4					
	documentation shared					9	
	- records not shared		6	9, 15			
	parent held records - in use						
	parent held records - being implemented		13				
	computerised record - Comcare					11	5
	social service assessment:						12
	- reams of documentation						12
	- used to release resources						

Appendix 6M: Table 4	STRUCTURAL CONDITIONS	HV1	HV2	HV3	HV4	DN1	DN2
timing/resources	time - accountable, restrictive				3		
	lack of time:						
	- to explore services; look at caseload/needs as a whole; develop skills; to complete profile; to develop services to meet needs			2, 7	3, 9, 17, 18		
	- due to covering vacant caseloads; staffing problems		18	7	19		
	- just covering basics	13					
	- reduction in HVhours: skillmix team		22				
	- inhibits client-sensitive timing of service provision			15			
	non-specifically aware of resource constraints					22	
	assessment influences:						
	lack of resources to meet needs; limits assessment of provision required		17		9		3
	knowing resources available in area - formal & informal services						
prioritising/using resources	achieving priority when required				9		
	multiple assessments before response achieved	2/3					
	negotiating with GP for child to be seen	9					
	'keeping in contact' to prioritise		17				
	documented 'evidence' to release resources						12

Appendix 6M: Table 4	STRUCTURAL CONDITIONS	HV1	HV2	HV3	HV4	DN1	DN2
service specification	purchaser agreement/GPs:	1	15	6	3		
	- emphasises quantity, figures		17				
	- priorities dictated by policy						
	- extending from traditional (under 5s) role			6			
	- not limited to specified visits			12, 16			
	Trust service philosophy:						
	- not influential in practice		16				
	- 'couldn't tell you detail'			19			
	- 'I've flicked through it'						21
	client centred in theory:						
	- reality depends on GPs	9					
	- emphasises quantitative aspects in practice		17				
	- resource and policy driven, not client led				21		
	- achieving targets prioritised above perceived client needs (?GP perception vs HV perception)				3		
	- limited choice, despite policy						7
targets vs assessed needs	eg, overall need for preconceptual care in area of high premature births not prioritised				3		
	GP funds perceived as used for meeting targets, not needs				3		
targets vs client choice	families who refuse immunisation removed from GP list				4		
	'travelling families' disadvantaged by immunisation targets				18		
	Trust view vs client perceptions	2					

Appendix 6M: Table 4	STRUCTURAL CONDITIONS	HV1	HV2	HV3	HV4	DN1	DN2
strategy/practice gap	targets and policies set by people 'higher up'						
	- who are 'out of touch'				18		
	- who are unaware of situation at 'ground level'						8
	- who do not listen to practitioners				18		
	feedback about client/practitioner input						
	- 'nothing back' from Trust board						
	- takes too long					27	
	client choice:						7
	- high profile policy, insufficient resources						6/7
'approved' work	scheduled visits:				5		
	Charter guidelines state number of visits to expect				23		
	purchaser agreement: when to visit		2				
	scheduled developmental checks	10		22			
	follow up DNA immunisation			6			
	visit according to need:						
	taught in College- have to have a reason to go				11		
home visits	not valued by Trust		9				
	valued by HV:						
	for developmental check	6	9				
	for all assessments - ideal for assessment	6		17			
	as part of total work		13				
	for immunisation non-attenders			6			

Appendix 6M: Table 4	STRUCTURAL CONDITIONS	HV1	HV2	HV3	HV4	DN1	DN2
short term vs long term	short term working contract influences long term planning for caseload				19, 21		
	apparent increase in short term projects				24		
	- one-off project to assess needs in area					2	
	immediate needs distract from long term; deeper needs hidden; records differ for long or short term			1/2			5, 10
	'upheaval' from fundholding distracts from long-term planning					5	
developing policies/strategies	working party includes practitioners						
	- for standard setting				23	17	
	- for developing strategy			19			
	- for developing new records						4
	- threatened by resource/time pressure					26	
				19	23		
	individual practitioner/opportunity to comment						
				19			
	lead nurse/manager known/named					4/26	
	profiling used to determine service strategy					3	
	not encouraged to question						9

Appendix 6M: Table 4	STRUCTURAL CONDITIONS	HV1	HV2	HV3	HV4	DN1	DN2
areas of responsibility	in working together; not taking on sole responsibility; determining responsibilities (DN or social services)				8	9 10	
	knowing/accepting own limitations /recognising situation is outside DNs control				20		11
	knowing where/how to get more specialist advice						
	being honest with the client; being open				20		
	recognising client's responsibility and choice; in relation to parent held records; responsibility for passing over information				13		
	GPs responsible for identifying/using skills in team				24		
	GPs apparently entitled to ignore HV referral	8/9					
	Trust responsible for identifying needs	2					
	professional responsibility						
	- to give information				14		
	- to act as advocate for child	3					
	- at different levels, in skillmix team		23				
	- for own learning		19	20			
	- to maintain role integrity		22				
	- to provide service to the area			16			
	continuing responsibility, despite referral		3	5			

Appendix 6M: Table 5	LEARNING ABOUT NHS & COMMUNITY CARE ACT	HV1	HV2	HV3	HV4	DN1	DN2
what NHS & CC Act brings to mind	- links with social services and specific groups, eg elderly, special needs, learning disability			6	1		
	- purchaser provider split		3				
	- awareness of legal and social viewpoint (along with Children Act and Education Act)		3				
	- care management			5			
	- specific documentation						
	- pace of change; perceived negative consequences for patients						15 15/16
roles	CC Act clearly specifies roles, or				1		
	- need for roles to be more specific	3					
joint working	especially in formal or specific situations - special needs , child protection issues			5	1, 7		
learning about CC Act	experience is essential				7		
	not yet experienced working with CC Act	3					
	paradoxical need for theoretical input, but can only make sense of it in practice				24		
	learn through quiz and workshop					6	
	multi-disciplinary learning					7	
	'brought up a lot'					30	

Appendix 6M: Table 1	NEED	HV1	HV2	HV3	HV4	DN1	DN2
need as a holistic concept	encompassing different aspects				1		
	- physical, social, environmental, psychological, mental,		1	5, 7			10
	- encompassing different levels; superficial to deep		1	18			10
	- community wide to individual			1			
need as a 'virtue'	aim to visit according to need				11		
need as a single element	specific or short term need described, eg sutures					2	
need as a complex issue	as a continuing issue						
	- continuing factor through the caseload				2		
	- continuing process	11					
	as a changing state						
	- different today		10				
	- daily assessment required					5	
	- as a personal perception						9
described in relation to client - actual or example	examples - smoking; cot death, child immunisation; stresses on a particular family; woman's need for refuge, unemployment, heart disease	1	8-9	1	4 11 20		
described in the abstract,	'picturing need', or difficult to conceptualise				20		9
or non specifically	in relation to area as a whole;					2	
	- needs on caseload as whole			20	2		
	- need as public health issues				17/18		
	-						
	in relation to service provision						3

Appendix 6M: Table 1	NEED	HV1	HV2	HV3	HV4	DN1	DN2
health and social together	as an ideal		16				
	all part of a person's well being			18			
health and social needs not separate:	- never considered separating them			18			
	- hard to separate in practice (eg consider family dynamics, social network/family)	11					
health and social described together in the abstract	health and social needs/social aspect of their lives		14				
	models encompass physical, social, psychological and environmental; mental		1	8			
through definition of health	'it depends on how you describe health'			18			
in examples	eg, situations of poor housing, accommodation		21		16		
	social networks and mechanisms; social isolation,	11, 7	21	10, 18			
	different cultures, interactions; social stimulation						3
needs - hidden or potential needs	seeing beyond appearances: need for awareness		7	9		6	6
	consciousness of need, unspoken by client	2		7			
	- of missing hidden need				11		
	prioritising needs: present now, or in future		1	2			
	looking to the future: physical health needs,		8				
	predisposing factors, 'previous history',		9, 18	10, 11			
	underlying problems, family issues, bereavement		20	12			
	background knowledge of situation					6	
	'want' viewed as adeeper level of need						10

Appendix 6M: Table 1	NEED	HV1	HV2	HV3	HV4	DN1	DN2
unpredicted or unexpected needs	examples of unpredicted needs arising	2, 6	20	10, 11	5		
	awareness of need to be 'prepared for the unexpected'; possible crisis situation				15, 16		
	awareness of skills required for unpredicted situations				16		
	'depends what comes up'			15			
client perceptions	acknowledge importance of clients perspective	1					1
	'ownership' - whose needs?		9, 18				9
	recognition of varied perceptions - client, community, professional, Trust	1		5			
specification of need in service contract	need vs want						1
	acknowledges client viewpoint	12					1
	Trust identifies need	2					
	need specified as 'figures'	1					
	emphasises quantitative aspects		15				
specific examples given of 'need', or factors contributing to it named	premature births, speech difficulty, sudden infant death syndrome, diet, iron deficiency, unemployment, dental problems/tooth decay, social stresses, post-natal depression, 'predisposing factors', heart disease	1, 8	2, 7, 9	20	2, 9, 14		

Appendix 6M: Table 2	NEEDS ASSESSMENT	HV1	HV2	HV3	HV4	DN1	DN2
targets/activities mentioned in relation to need	immunisation figures, child surveillance, development checks, physical checks		8		3, 4		
	administrative aspects carried out at assessment visit		13	9, 15		11	
level of need: individual	conceptualised as applying to one individual only - limited input required				1	2	
	awareness of need to assess individuals within family situation			10	5	6	
	avoid narrowing down to individual			12			
	records relate to individual only			10			
specific aspect of need	singled out as part of wider assessment:						
	- physical assessment, bilirubin, Mum's Hb, post-natal depression scale, child protection, labour;		8, 9, 15	4, 10, 15			
	Scriver		7				
	- remembering important single elements in complex situations		11				
assessment as a single event	distinguish short term from long term needs:						5
	short -term = single assessment						11
	short term = superficial level						11
	initial assessment:						
	overview, follow up in more detail later			16			
	thorough assessment needed to start						2

Appendix 6M: Table 2	NEEDS ASSESSMENT	HV1	HV2	HV3	HV4	DN1	DN2
level of need: family - interactions, resources, whole family system	conceptualised as a family issue; central to assessment - extended family, family support, family networks, family relationships, background relationships, cultural issues, general environment	6	2, 3, 3, 5, 7, 8, 8, 14	3, 4, 7, 9	4, 6, 6		
	conscious effort to include family members		8				
	awareness of importance of family influence; coping with family		8	9, 11, 13		6	3
	family records			9	6		
	multiple aspects at once	4		9			
level of need: caseload, area or community	caseload as a whole; area		14,	16	2	2	
	- associated with health promotion					3	
	culture/ethnicity	7, 11					
	specific measures: Jarman		5	20			
	specific issues: chemical factory, dog dirt, roads			8			
needs assessed within a context -	recognising usual patterns in area; local family cultures; understanding 'reality'; families supported or not; family dynamics; interactions	11	8	18	6		3
	assessing environment/ knowing area; addresses; housing		7	9, 16		12	
	neighbourhood/area resources and services - available or not; neighbourhood study; need for wider than individual action				16, 20		

Appendix 6M: Table 2	NEEDS ASSESSMENT	HV1	HV2	HV3	HV4	DN1	DN2
'intuitive profile'	informal assessment at a caseload or area level	8					
	'things that come to mind' 'you are doing it subconsciously all the time . . '				2, 2		
	'identified something . . '			20			
	'you can see what people need'					23	
'intuitive assessment'	informal assessment of need at an individual or family level:						
	awareness of unspoken need	2	2, 7, 12	3, 4, 8			
	- 'picked up on', 'chatter about', 'just see how she is' 'general conversation', 'information changes place', 'just watching them' (children)			22			
	overview assessment - not at deep level			16			
	awareness of hidden needs; making opportunity for client to talk, 'just mention' issues	7		10, 11			
systematic assessment	' formal' assessment distinguished			3			
	use of models for assessment		13	7, 20			
	- Worcester models, Becker, Clark		2, 13				
	- Orem, Robinson, family tree, Becker			8/9			
	- Orem Maslow					10, 25	18
	purchaser agreement for specific assessments		13				
	assessment of area prior to planning services						1
	assessment in relation to records			10			

Table 2	NEEDS ASSESSMENT	HV1	HV2	HV3	HV4	DN1	DN2
continuing assessment	by staying in touch (phone calls, clinic)		14	17			
	several visits for detailed assessment			15, 16			
	daily assessment					5	
	initial assessment just starts relationship						2
	starts with single 'specific' (issue, or individual)	5/6	2, 7	8,9		1	
	then widens out; continues over longer time						10
profiling valued	benefits/importance acknowledged by practitioner		1	2	20		
	aware of complexity; national vs local comparison		5	21			
	basis for planning work, seeking resources			20		23	6
	has completed profile on own caseload	4	18				
	compiling profile in own time			2			
	locality manager completed practice profile					4	
	could show health promotion needs					5	
	used as systematic approach to prioritise		18				
	caseload weighting/scoring system considered		5, 18				
	need for computer system link		6				
	used for College assignment					5	
low value on systematic assessment	needs afforded low priority in area despite assessment				3		
	- traditional patterns of work continue, despite assessed needs			1			
	'getting the work done' is the priority			2	8, 17		
	- immediate needs, not long term			1			
or profiling in general	unrealistic to do community profile:						
	- time pressure; difficult to do			1, 2			
	- GPs do not want profiles				17, 24		
	records not conducive to profiling		5				
	not really thought about it yet					29	

Appendix 6M: Table 2	NEEDS ASSESSMENT	HV1	HV2	HV3	HV4	DN1	DN2
health and social divide	linked with service responsibilities in formal assessment situations, eg special needs; child protection issues; Community Care Act; elderly, mentally ill, physically disabled				7, 1		13
	health and social services have: - different responsibilities			18			7
	- separate assessments						12
	linked with specific examples of social need, eg poor housing, family centre,			5	16		
	used to avoid work overload (DN)					26	
timing/resource pressure	time needed to get to know people and area				3		
	accountable for time		13		3		
	caseload and time pressure; lack of time	13	17		17, 18, 19		6
	timing assessment/questions to meet client need	5	2	10	16		
	assessment starts prior to contact		7	4		2	5

Appendix 6M: Table 3	ASSESSMENT IN THE CONTEXT OF EVERYDAY WORK	HV1	HV2	HV3	HV4	DN1	DN2
assessment requires 'getting to know'	getting to know clients and their ways						
	- takes time; several visits to 'unravel'	6, 12			3		
	- facilitated by home visits	8					
	getting to know area, caseload or services	3, 12			3, 20, 21		
	- takes time; needs experience						
	- awareness of whole caseload		21				
and 'being known'	people need to know professionals as individuals				15		
assessment as a continuing process	one visit insufficient:						
	- for assessment purposes	6, 7			5, 15,		
	- to allow response to unexpected needs				15		
	staying in touch						
	- in rapidly changing situation					6	
	- as a means of assessment		12				
	- reduces need for formal assessments		17				
	- assessment continues as long as in contact with family			16			
	ideally, would follow up all families			15			
relationship to workload	fitting assessments in with other priorities; 'juggling'; time restraints		17 18				3, 5
	ensure allowance for unexpected caseload pressures (case conferences etc); 'prepare for the unexpected'; pace of change			15			8
	skillmix team increases management role/frequency of assessments		23				

Appendix 6M: Table 3	ASSESSMENT IN THE CONTEXT OF EVERYDAY WORK	HV1	HV2	HV3	HV4	DN1	DN2
assessment as a starting point	planning						
	- follow up;				6		
	- joint planning				8		
	- for opening up issues	10		10, 11			
	- for informing clients of services		14				
	- for future needs			4, 11			
awareness of wider skills	discrimination skills:						
	-when to raise issues (eg, communicate with client, mention child protection concerns or smoking)		10	10, 13, 8	16 6		
	eliciting hidden/unexpected needs				17		
	communication skills central					16	2
relationships with colleagues	'working together' as an everyday event				10		
	- working with other team members (GP, midwife, Practice Nurse, HV, PHCT)	9		7		3	
	- liaison; updating (social services, social workers)				10	8	
relationships with clients	information sharing builds relationships				13		
	relationships central to assessment						
	openness builds relationships				13		
	less need for formal assessment if 'relationships' exist		15				
	assessment builds, or starts, relationships			3			2

Appendix 6M: Table 3	ASSESSMENT IN THE CONTEXT OF EVERYDAY WORK	HV1	HV2	HV3	HV4	DN1	DN2
questions about needs assessment answered in terms of whole work situation	without apparent consciousness, eg: in relation to 'getting to know' family; adjusting to family's needs; awareness of specific intervention or explanation; 'knowing' family prior to assessment; working with strengths, deficits, problems, giving information, to emphasise the positive	6	2, 7, 14	9, 10 12 4, 18	14		
	apparently consciously, eg: in terms of completing records to facilitate profile		6				
role of client in assessment	- clients aware of services and what they want from them				15		
	- family members facilitate assessment eg, taking child out of room		7				
	interpreting (caution)	(seen)					
	- or prevent it				6		
	client resources influence assessment process (eg, social support, access to telephone)		8, 17				
	- reaching agreement with families about roles in carrying out plan			5			
	- accepting client viewpoint			9			

Appendix 6M: Table 3	ASSESSMENT IN THE CONTEXT OF EVERYDAY WORK	HV1	HV2	HV3	HV4	DN1	DN2
assessment and records	inappropriate format:						
	- individuals only			9			
	- records inhibit use of models			8		11	
	- insufficient space or detail					12	4
	- 'outdated'					11	
	changes to record format planned			22		11	4
	completing records - at assessment			15			
	- for sharing information; care planning	4					
	documentation shared					9	
	- records not shared		6	9, 15			
	parent held records - in use						
	parent held records - being implemented		13				
	computerised record - Comcare					11	5
	social service assessment:						12
	- reams of documentation						12
	- used to release resources						

Appendix 6M: Table 4	STRUCTURAL CONDITIONS	HV1	HV2	HV3	HV4	DN1	DN2
timing/resources	time - accountable, restrictive				3		
	lack of time:						
	- to explore services; look at caseload/needs as a whole; develop skills; to complete profile; to develop services to meet needs			2, 7	3, 9, 17, 18		
	- due to covering vacant caseloads; staffing problems		18	7	19		
	- just covering basics	13					
	- reduction in HVhours: skillmix team		22				
	- inhibits client-sensitive timing of service provision			15			
	non-specifically aware of resource constraints					22	
	assessment influences:						
	lack of resources to meet needs; limits assessment of provision required		17		9		3
	knowing resources available in area - formal & informal services						
prioritising/using resources	achieving priority when required				9		
	multiple assessments before response achieved	2/3					
	negotiating with GP for child to be seen	9					
	'keeping in contact' to prioritise		17				
	documented 'evidence' to release resources						12

Appendix 6M: Table 4	STRUCTURAL CONDITIONS	HV1	HV2	HV3	HV4	DN1	DN2
service specification	purchaser agreement/GPs:	1	15	6	3		
	- emphasises quantity, figures		17				
	- priorities dictated by policy						
	- extending from traditional (under 5s) role			6			
	- not limited to specified visits			12, 16			
	Trust service philosophy:						
	- not influential in practice		16				
	- 'couldn't tell you detail'			19			
	- 'I've flicked through it'						21
	client centred in theory:						
	- reality depends on GPs	9					
	- emphasises quantitative aspects in practice		17				
	- resource and policy driven, not client led				21		
	- achieving targets prioritised above perceived client needs (?GP perception vs HV perception)				3		
	- limited choice, despite policy						7
targets vs assessed needs	eg, overall need for preconceptual care in area of high premature births not prioritised				3		
	GP funds perceived as used for meeting targets, not needs				3		
targets vs client choice	families who refuse immunisation removed from GP list				4		
	'travelling families' disadvantaged by immunisation targets				18		
	Trust view vs client perceptions	2					

Appendix 6M: Table 4	STRUCTURAL CONDITIONS	HV1	HV2	HV3	HV4	DN1	DN2
strategy/practice gap	targets and policies set by people 'higher up'						
	- who are 'out of touch'				18		
	- who are unaware of situation at 'ground level'						8
	- who do not listen to practitioners				18		
	feedback about client/practitioner input						
	- 'nothing back' from Trust board						
	- takes too long					27	
							7
	client choice:						
	- high profile policy, insufficient resources						6/7
'approved' work	scheduled visits:				5		
	Charter guidelines state number of visits to expect				23		
	purchaser agreement: when to visit		2				
	scheduled developmental checks	10		22			
	follow up DNA immunisation			6			
	visit according to need:						
	taught in College- have to have a reason to go				11		
home visits	not valued by Trust		9				
	valued by HV:						
	for developmental check	6	9				
	for all assessments - ideal for assessment	6		17			
	as part of total work		13				
	for immunisation non-attenders			6			

Appendix 6M: Table 4	STRUCTURAL CONDITIONS	HV1	HV2	HV3	HV4	DN1	DN2
short term vs long term	short term working contract influences long term planning for caseload				19, 21		
	apparent increase in short term projects				24		
	- one-off project to assess needs in area					2	
	immediate needs distract from long term; deeper			1/2			
	needs hidden; records differ for long or short term						5, 10
	'upheaval' from fundholding distracts from long-term planning					5	
developing policies/strategies	working party includes practitioners						
	- for standard setting				23	17	
	- for developing strategy			19			
	- for developing new records						4
	- threatened by resource/time pressure					26	
				19	23		
	individual practitioner/opportunity to comment						
				19			
	lead nurse/manager known/named					4/26	
	profiling used to determine service strategy					3	
	not encouraged to question						9

Appendix 6M: Table 4	STRUCTURAL CONDITIONS	HV1	HV2	HV3	HV4	DN1	DN2
areas of responsibility	in working together; not taking on sole responsibility; determining responsibilities (DN or social services)				8	9 10	
	knowing/accepting own limitations /recognising situation is outside DNs control				20		11
	knowing where/how to get more specialist advice						
	being honest with the client; being open				20		
	recognising client's responsibility and choice; in relation to parent held records; responsibility for passing over information				13		
	GPs responsible for identifying/using skills in team				24		
	GPs apparently entitled to ignore HV referral	8/9					
	Trust responsible for identifying needs	2					
	professional responsibility						
	- to give information				14		
	- to act as advocate for child	3					
	- at different levels, in skillmix team		23				
	- for own learning		19	20			
	- to maintain role integrity		22				
	- to provide service to the area			16			
	continuing responsibility, despite referral		3	5			

Appendix 6M: Table 5	LEARNING ABOUT NHS & COMMUNITY CARE ACT	HV1	HV2	HV3	HV4	DN1	DN2
what NHS & CC Act brings to mind	- links with social services and specific groups, eg elderly, special needs, learning disability			6	1		
	- purchaser provider split		3				
	- awareness of legal and social viewpoint (along with Children Act and Education Act)		3				
	- care management			5			
	- specific documentation						
	- pace of change; perceived negative consequences for patients						15 15/16
roles	CC Act clearly specifies roles, or				1		
	- need for roles to be more specific	3					
joint working	especially in formal or specific situations - special needs , child protection issues			5	1, 7		
learning about CC Act	experience is essential				7		
	not yet experienced working with CC Act	3					
	paradoxical need for theoretical input, but can only make sense of it in practice				24		
	learn through quiz and workshop					6	
	multi-disciplinary learning					7	
	'brought up a lot'					30	

Appendix 6M: Table 6	COLLABORATIVE, JOINT AND TEAM WORKING	HV1	HV2	HV3	HV4	DN1	DN2
collaboration, joint working	working together:						
	- is policy			19			
	- is required in formal or specific assessment situations				1, 7		
	- at care planning meetings; monthly discussions; discharge planning for complex cases					1, 8, 9	
	- working party to plan collaboration						6
	'working together' as an everyday event						
	- team work, liaison, interdisciplinary work,	3			10, 22	2	
	working closely with other services			5		25	
	- good PHCT; PHCT meetings					3, 28	
	- sharing knowledge informally in team		10		2		
	- work jointly to plan for family; set up agreements; decide roles			5		1	
	- completing records for anyone taking over; shared records	4				9	
	- or not: no sharing of records		6				
	communication						
	good with social services; Fax machine						
	poor with surgical ward; discharge planning					17	
	problems					19	19

Appendix 6M: Table 6	COLLABORATIVE, JOINT AND TEAM WORKING	HV1	HV2	HV3	HV4	DN1	DN2
referrals	recognising need to make referral				8		
	'working up the referral' - client		3		9		
	'working up the referral' - GP	9					
	making referral - formally	3		5			
	making referral - informally ('have a word with')		3, 3				
	retain responsibility, despite referral			5			
	relinquish responsibility, through referral					1	
	referring via GP: problematic	9					
	referring may mean multiple assessments	3					
	receiving referral					2	
	- designing referral form					28	
	- unclear or inaccurate communications						20
skillmix team	delegation = more assessments needed		14/15				
	staff nurse: follow up visits, elderly visits		21				
	information/training required: reporting back, child abuse, collaboration with GP, school nurse		21, 22				
	NNEB: not assessors			17			

Appendix 6M: Table 6	COLLABORATIVE, JOINT AND TEAM WORKING	HV1	HV2	HV3	HV4	DN1	DN2
fitting in with team	'finding your feet'						
	avoid ruffling feathers; go with the flow				21, 18		
	find out about other services and about		13				
	changes/pressures affecting colleagues		11/12				
	avoid upsetting applecart						9
	'avoiding conflict'						
	not contradicting colleagues' advice		8				
	not repeating assessments			10			
	smooth team working						
	respect each other's role in team			7		5	
	recognising pressure and low morale in colleagues				18		
maintaining enthusiasm despite team!	traditional role maintained:						
	- under 5's only as the norm	12		6			
	- new ideas/suggestions rejected by colleagues				2		
	morale						
	- 'reality' = heavy pressure and low morale				18		
	- lack of enthusiasm in colleagues						9
	- working in a 'climate of fear'						9
	working with GPs						
	- difficult to find a GP to trust	9					
	- contrast: great faith in GPs!					21	
	HVs assessments						
	- not accepted by GP/other team members	3					
	- contrast: are accepted by other team members			7			
	potential role dilution with skillmix team		22				

Appendix 6M: Table 7	CLIENT CENTREDNESS?	HV1	HV2	HV3	HV4	DN1	DN2
attitudes required for client centred service	explicit recognition of client choice; 'there for them'		18	10, 13	6		
	explicit acceptance of client perceptions; of self-assessment; explicitly non-judgemental; encourage to write in records	7	8	9	14	12	1
	recognition or explicit valuing of client views/perceptions;	1, 2	11, 13	13			
	openness and honesty valued -				13, 20		
	but ?hidden agenda nevertheless			4	14		
	need for flexibility of approach recognised	10	8			12	2, 5
	acknowledge variable perceptions/ownership of need		7, 9, 14	1			9
	awareness client rights and privacy			9, 13			
client/consumer view valued	'ideal vs real' client led is ideal; probably service is resource-led and professionally led				15, 21		
	profile being used to identify client views					3	6
	social services promote listening to clients						7

Appendix 6M: Table 7	CLIENT CENTREDNESS?	HV1	HV2	HV3	HV4	DN1	DN2
skills required	communication skills central	13			16/17		
	- sharing information/working in partnership				13		
	skills of facilitation		15				
	discrimination skills:						
	-when to raise issues or refer on		10	13, 15	16		
	- aware of own knowledge in relation to client perceptions		15		6 17		
	eliciting hidden/unexpected needs			8	14		
	- using systematic approach to 'trigger' discussion			8/9			
	involvement of family in care planning					9	

Appendix 6M: Table 8	EDUCATION AND PRACTICE OF NEEDS ASSESSMENT	HV1	HV2	HV3	HV4	DN1	DN2
use of resources:	colleagues;						
	for discussing needs; to check perceptions of				2,		
	needs; to find out about area; to discover different						
	approaches to assessment; to check decisions;			21		13	
	gaining support from team					9	
	period of preceptorship				19		
	learning from specialist nurses					16, 17	
	finding out about local facilities; knowing and				19		
	being known; using strategy documents for information			20	20		
working within resource constraints:	getting 'bogged down'; no time for what needs doing	13	16, 18		18		
	learning to prioritise within caseload			12			
	no realistic awareness of resource constraints					21	
application of theory to practice	realise relevance of theory when you start in post			21	16		
	importance of practising reflecting on practice;				17		15
	use of 'reflective chronicle'			21			
	practice using models for assessment helpful;		3, 21	7			
	carrying out case studies						
	role/skills of CPT in debriefing/teaching important		19			13	
	group work/discussing scenarios/role play: useful			21		14	
	multi-disciplinary workshop - learning from each other					7	
	gaining practical experience;						
	taught practice and supervision period important					8, 13	
	consolidation after completion important						22
	'not a lot' of theory in College					30	

Appendix 6M: Table 8	EDUCATION AND PRACTICE OF NEEDS ASSESSMENT	HV1	HV2	HV3	HV4	DN1	DN2
developing awareness	- of need for persistence				3		
	- of need for long term approach				3, 12		11
	- of need to develop advocacy and political skills				21	20, 26	
	- of conflicting needs and cultures within families	14	9		7, 14		
	- of different cultures (ethnicity)	7					
	- of different perceptions of need			1			
	- of need to be adaptable						2
developing confidence	- in child protection work	3	20				
	- in assessing child development			23			
	- in handling unexpected situations						
	- to question other services				9		
	- in own judgement			3			
	- in broad knowledge base			13		10, 16	
	- in terminal care					25	
	- to market services	9		2		28	
developing skills	- of making referrals		3				
	- of facilitation		15				
developing professional responsibility	- broader awareness of role		23				
	- role in relation to others			17			
	- accepts own responsibility for learning		19	20		16, 19	
	- seeks support in developing self-directed learning					13, 14	24
	- considering further education					32	

Appendix 6N - Table 1a

Concept of Need Compilation of data elements from the HV files

Attributes / antecedents / conditions
Need Definition characteristics

Expressed need of clients address as a **priority**
Priority need
client **wants,**
Very much individual as a person
expressed need of individual
expressed need of a group
expressed needs of the population
Obvious Needs as in an area ie poverty
Need as very important to individual
Gender differences in need
profound need absolutely expressed
whereas perhaps **in another area** you wouldn't even consider it,
may not be instantly recognised by the person or group
people may be aware of a needs,not aware there are things to help a difficult situation.
not always able to articulate need

Defining need
Clients and professionals views of need
something that HVs **recognise** as a professional
within a **certain situation (context)**
something almost a subconscious thing **(intuitive)**
individuals may not have actually said it to anybody **(knowing something's not right)**
something at the back of individuals mind thinking about something and wanting to do

Discrepencies in need definition
perhaps **in another area** you wouldn't even consider it as a Need
some differences in women and men
Practitioners must be able to adapt what you see as being a need to the clients view of needs

Purpose in assessing and defining need
Purpose in assessing need is to provid services, need and resources are linked
Determined whether need known publically or high on agenda
Not a priority because it isn't a headline issue
Something to get involved in to ensure that
new hv have opportunity to do something about needs

Need and resources
Two prongs to practitioner's work;
Meeting clients expressed need and meeting needs determined by HV
flexible approach listen to what the client wants,and **respond to that need.**
visiting based on **responding to the needs of clients**

Need Not seen as a priority
because it isn't a headline issue
Determined whether need known publically or high on agenda
people with a wider range of needs no scope for channelling needs towards people who might provide resources
Fitting individuals need into existing services that occurs
when there is no services to fit need it is important that the client should not feel, they don't fit

into a pigeon hole,when you don't have a service that can occur

Need as abnormal behaviour
not always acknowledged or recognised by client
working with clients identifying need, clearly seeing need from child's abnormal behaviour but the client does not, has to be done very gently.
Outcomes to assessing need
we were able to refer, coming to a resolution, to have a positive outcome.

Education preparation for need

Models of need in College
Not a great deal.Not specifically I don't think.**Did nursing models**
Orem, Models used for family study Maslow Roper nursing models
Bradshaw's Taxonomy of Need examined more in the **health promotion role**
in **assessing people's needs We looked at health first,**
what was meant by health,How we see health,
Different sort of health needs kinds of, respect for needs
case studies used Newman Model for famil study

Outcomes of using a model
knowledge helps you to assess people helps frame your assessment
knowledge of the theory of need helped you to be adaptable and flexible
it gives you a focus
Areas that **relate to clients views**
what they see as being healthy and being able to enjoy life, get the most out of life,
Guides **assessing people's needs**
Different sort of health needs.
got to be flexible and look at different perspectives when defing need.

Selecting a model
Using **one model** would be too rigid,because
you'd only be looking at it from one person's viewpoint,knowledge of the theory of need
I don't think you can do that
you've got to be flexible and look at different perspectives when you are looking at need.

Knowledge of need helpes you to be adaptable and flexible

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Appendix 6N - Table 1b

Concept of need compilation from district nurses data
District nurses

Need

DN 2505
Defining need
The word need is very subtle care in its use
Need is about perception, need is how people see it
2405 linked to personal views

2605
Different **degrees** of need,
2405 simple complex
Basic needs to survive, for example, food and warmth and that kind of thing,
Society other needs for example, a social network ,health and leisure ,
dn 2305 2405
Need is Concerned with upbringing the area in which they lived, the environmental factors, the physical factors, I don't think it's linked to one thing, it covers a larger area you've got to draw in everything.

dn 2305
Comparative need Equality and Inequality of need
Want and need compared with what others have
Need determined at a distance in financial distribution see script for example
clients don't always assert themselves
2305 Uniformity consistency seen as the best Comparablity
Need for uniform everybody getting the best service available

2304 2405 2505 2605 individual need holistic personal
2305 2405 25052605 social and health can't separate tied together
2405 health need and other needs
2505 2405 More complex and multiple single than anticipated a common phenomenon within d/nursing
Nursing work concerned with need
what is Health and what is Social
who determines Social Health
when does a Social problem become a, Health problem or when does a Health problem become a Social problem?
The two are too intertwined that you can't separate them.

dn 2505
Need beyond the individual need in the context of the whole
The wider aspect of need
Different levels of need besides the individual level
Need within the wider Community (practitioners area) practitioners perception
example, observation/ there is a need to cut smoking for a start that's an outstanding need to me.
2405 needs of community actual need of a population
dn 2505 2605 2305
Discrepancy in need definition
professional's perception of person's needs. may be quite different from
may not be what the patient want at all.

2505 dn

Unpredictability

Needs they can suddenly change and require a lot of extra input, even where there is a supportive family, good backup from the Social Services

Hidden needs

Chiropody a hidden need not picked up on a profile

dn 2305

Professionals and their perception of need

Professionals often seen as interfering busybodies.
Not District Nurses, but Health Visitors wary of staff in particular social workers
Social Workers only go when there's trouble,
Health Visitors only maybe go to problem families -

dn 2605

Need and Want two diverse things
classified

Need things that enable people to be stay healthy safe in their own home,
Want might be the things that would make them happy
need and want not always the same
Governed by clients and professionals own standards

Difference between **need and want** constrains what people get
Involves and Determined by perceptions of others
Perception of the professional assessing
whether it's warranted or not available It can be both

dn 2305

The impact of, culture and environment on need and meeting need.

Perceptions and Difference between need and want
what client wants may not be what they need often don't know what they need especially in areas like this,
Do not know what services are available they are not advertised. They've always managed on their own in close knit communities and never bothered with professionals.

dn 2605

Cultural difference in need perception

Perceptions of the GP's differ as to what people need
Coloured doctors referrals differ from white doctors.
White doctors request socially oriented assessments bath and social assessments
Coloured doctors always medical, and nursing oriented
Coloured doctors think people in this country are not self reliant too reliant on statutory services
Believing people ought to, look after their own more than they do here.
I've pointed out that the Health Service itself has perhaps made people reliant on services and that more women working now and families moved away to different areas there isn't the support network. Yet they still think people in this country rely too much on state help

dn 2605

Impact of definition on clients need led services (The fine line)linked to illness

needs keeping someone out of depression referring for Day Care or Luncheon Club, whereas someone **wants** company, where do you draw the line, what is your role if, it's to help them maintain a optimum of health really

Need linked to services Meeting needs

needs support at home, supportive family backup from the Social Services

Reality

Professionals determine the optimum and depends on the resources
Practitioners Have to prioritise what we can do for people.
dn 2605
dn 2505
The politics of need, Defining need
(What is need anyway) Changing perceptions
Washing, basic washing, now that's a bone of contention as to whether washing is a Social or a Health need, fought about for years, there's something about the washing of the body that has a different status at different times
2305
A changing belief system
bathed everybody skin is kept clean jeopardise skin's integrity.
that's changed it not valuable any more
there's an awful lot of grey areas so grey

Assessing need
dn 2505 2605
Awareness of need informing patients improve their knowledge,
stimulate thought, informing and enabling patients to recognise need and signs enable themselves to develop skills to cope
Recognising, Documenting need, and unmet need
need is often documented -Example Need for Chiropody is documented **but** that's up to the
2405 need requires practitioners to ask questions to gather more information.
GP's. yet identified needs not being translated into a service.
Articulating identifying need /need ownership/ responsibility /accountability
we need to actually document it but does not always mean its heard
2405 linked to assessment
linked to providing care
need linked to the provision of services
need linked to what services are available

dn 2505
Need /
As Controlling / Rationing/ Manipulating service provision./Unmet need
Care Manager has to think of the cost.
told we need to provide the client with what they want -within reason,
Has to be a ceiling, things have to be tailored, because there isn't a bottomless budget
what the clients wants is still determined by the resources

Vacillating incremental needs judging
Impact of intervention in meeting needs
Multiple needs to start with now she's organised the needs change
2605 2305
Education for need
Cant recall what was learned about the concepts of need in College
Values of research on need in Psychology and other subjects
Bradshaw's Taxonomy of Needs
Lectures and talks from other professionals who came to talk about Care Management
A District Nurse talked to us about needs of carers
Learnt about things for the exam and then forgot.

Appendix 6N - Table 2a

Concept Individual and family HVs

Antecedents / Attributes / conditions

Family visiting
individual in the family
Child not always the centre focus
needs of adult in the family had repercussions for the child,
support families maintain situation in terms of child protection
many levels of family and generations,

Working with families
Two way relationship
maintain trust Right to choose respect client decision requires warmth confidentiality access to records
Dealing with difficult decisions openness Honesty The fine line requires sensitivity
Sharing decisions requires honest accuracy impartial listening
parents have got their own agenda and want to talk to you about one specific thing
you have just got to go with the flow
you put your own agenda on hold really.

Principles in client centred approach in working with clients
important in working with clients in their home in community
encouraging enabling clients decision making clients discover for themselves
provide clients with options and choice a comfortable way of working with people.
encourage clients to fill in records.

Family assessment in specific situations

Registered Child abuse
Policy mother attended **care team meetings**
helps with the **openness** aware of their rights

Vulnerability, needs assessment danger signs so many needs
Require good detailed multidisciplinary needs assessment
not just a Health Visitor needs assessment
Social Worker and everything everybody
hopefully things will improve for her.

Documentation of family assessment.
Need family record one record card for the child particularly and one for the whole family
record is for assessment of any member of family information
recording at visit acts as a barrier very rude interferes in relationship with the client. could deters partnership development
I hope clients feel that we work well with them in partnership.

family record
probably condensed incorporating child and family prevent repeating information
more of a family record ableto add each subsequent child.
child health ones at the moment record bare essentials immun etc.,

Different approach to health Visitor directed

The impact of parent held records a research need,
offers clients a chance to agree or disagree to respond and write too

Questions appropriateness of family record and Child held record

Consequences Outcomes

Impact of parent held records
Not being used properly
concerned some Health Authorities were doing away with Health Visitor Records
relying only on parent health records some places finding it doesn't work.
Health Visitors and parents need records legal responsibilities
vulnerability of the parent held documentation as an issue.
Important having parents and professionals using the same health records inevitably
reality they can get lost, or deliberately destroyed or altered.
Where there are concerns about a child Hv's need objective records that can stand up in a Court of Law.

Reality of issues of partnership
Not always able to achieve due to situations and some needs and some families

Uncertainty in visiting clients.
Lack of knowledge about the family, makes you vulnerable they could be spinning you a tale.
Not knowing the past treat information carefully don't know
need to know what's happened in the past
Assess at face value without deeper knowledge of what's gone on within that family now or in the in the past

Thwarts to development.
Not always free to be responsive to need due to traditional role constraints

Uncovering need that can't be met, endeavour to meet at some point
clients get quite impatient Hs hurry the process along.

Outcomes of openness in working with family.
Positive aspects.
objectives clearer a joint way forward

for the client
Unsure if it does enhances partnership
So don't know if it is a better outcome for the parent or the child

For the practitioner
focuses work sets achievable goals clarity of outcomes
Mother knows exactly the aim
gives client confidence to communicate increase parenting confidence in children's development

Difficulties with inappropriate documentation

Ideal cases

Educational needs

Literature review
Working in partnership in Child abuse
Family visiting
Family nursing
Client centred care
Child held records

Appendix 6N - Table 2b

Individual and family carer assessment
Dimensions and skills
Attributes antecedents

dn 2505 The individuality of assessment
Assessments involve two people, may be differing perceptions of need
2305 Judge clients individually
build relationship give choice not take over the responsibility accept their personal standards can't push them into changing them, keep your own ideas to yourself.

Client as partner working with patients (client centred)
dn2506 different approach to the patient, plan of action between the two of us made conscious of it through training its what can I do for you not I've come in to do

Professional Judgement
dn2506 it's professional judgement that makes the decision, involves encouraging, advising on effectiveness Introducing ideas without objections A question of time, and building confidence.

Negotiating with clients Balance
dn2506 professionals there to provide a service for them **(dilemma)**sometimes backfires, Clients say "do what you think" some are dogmatic like to command, intractable problems

Communication between professional and client issues of confidentially,
Dn 2405 get patient and carer to actually talk about what they feel the needs are, Depends on relationship, always ask patient's permission to discuss. May be obvious reason why not want to divulge information.

dn 2605 The individual and the carer Ideology
Assessing carers needs part of assessing the patient's needs tied to the patient's care They're so interlinked, looked at a person holistically includes carers needs.
Patient and carer take equal priority

The practice Meeting carer needs
Carers needs not missed, just not done as a separate thing Don't need to be separate in most circumstances, have to consider the needs of the carer
Balance you've got to at look what the carer does otherwise things would fall down

Carer and professional Interaction
Dn 2405 Hard to meet both needs and keep both people happy. Usually carer catches you on the doorstep. Feel you're doing everything behind the patient's back

2505
Documentation
Documentation focused on the patient but have to balance carers needs
asks who is the main carer - how often the main carer sees the patient,
Carer information included in the nursing report at the back,

2505
??Separate assessment for carers
Carer needs have to be recognised, not assessed separately, Separate assessment not necessary, does not mean we're not meeting the needs of carers

Recording carers needs

2505 separate assessment will make documentation cumbersome. keep simple, easily read and referred to consider something on the Nursing Assessment sheet as part of the Care and Plan

Outcomes and consequences.
Exceptions
2505 More complex situations then you may need to see the carer individually that's not typical really, if the carer wants to talk to you privately, usually monitor that - quite easily

Documenting conflict
2505 between carer and patient documented on the nursing notes back at the base
Example collusion about a diagnosis for example,
where the patient or the carer didn't want the other to know, I would document that back at the base would not put that in the house record

dilemmas in dealing with collusion
2505 difficult where families adamant they do not want the patient to be told
Initial situation arises often in hospital
make opportunity to find out what the patient knows or wants to know.
speak honestly with the family They protect each other.
If a patient asks what's wrong they want to know, then I would let them know.

Professional constraints
2305 Tendency to assume responsibility for patients Patients should be given responsibility back nursing as helpers but not to take over, back-up service

2305
Balancing dilemmas in wants and needs
Can't, say what the patient want, Deal with situations individual it all depends on the patient.

2305
Choice The Rhetoric and the Reality choice about giving options about services
Choice is "very important ,we don't have a lot of choice in reality"
In theory choice sounds very good, but it all comes down to money,

2305
Actualising choice
Well we talk about educating the patients. Giving responsibility back to the patients.
Power is in education, in knowledge. Try to educate the patients the best you can

2305
Dilemmas is in realising this ideal
Some clients (Especially elderly) don't want to assume responsibility, want somebody to take responsibility for them you've got to give them choice" Yet how can you give pts a choice?
Quote "Reality is that there is no choice when you know your resources are limited".
All you can do is give them the best for the limited resources
Always determined the available resources as every area is differentt

Appendix 6N - Table 3a

Compilation of accounts of health visitors
Work + share with clients

Attributes antecedents conditions

Address **expressed need** of clients as **a priority**

two prongs to work; meet clients expressed need and HV needs
flexible approach listen to what the client wants, whether it be individual or a group basis, and respond to that need.
visiting based on responding to the needs of the population
records are always open for anybody to see.

Impact and use of parent held records (for professionals)
HV records often **deciding factor** in a child protection **in Court.**
held by parents.
Sometimes we **record** do not always record in them
Not being used properly

The impact of parent held records a research need, (for parents)
offers clients a chance to respond and write too
Concerns some Health Authorities were doing away with Health Visitor Records
relying only on parent health records some places finding it doesn't work.
Health Visitors and parents need records legal responsibilities
vulnerability for parent and professional of the parent held documentation as an issue.
Important having parents and professionals using the same health records inevitably
reality they can get lost, or deliberately destroyed or altered.
Where there are concerns about a child Hv's need objective records that can stand up in a Court of Law.

Trusts policy additionally hvs maintain traditional health visitor records
partly tradition partly because child protection is high profile
importance of keeping records has been shown a number of times just lately.

Maining both type of records
Keeping separate records and client led philosophy HV:(**?? Conflict**)
anything written discussed with client, no necessarily seen
Child protection issue,written reports based on Hv records
Shared with the parents who get a report copy prior to meeting or conference.
Do not record opinions write what has been said what has been discussed.

Paradox in Judgement
we use a **non judgemental approach.** No judgements are made about situations
don't make judgements about people just because of certain criteria,
Even though were using judgement judging every situation.
those **judgements viewed as different** I would say its more based on instincs.
If something doesn't feel right it needs to be discussed with the client.
Act on instinct at times, Honesty essential

Different approach to health Visitor directed
Principles in working with clients
client centred approach important working with clients home in community
encouraging enabling clients decision making clients discover for themselves
provide clients with options and choice a comfortable way of working with people.
encourage clients to fill in records.
Knowing thrusting

Appendix 6N - Table 3b

Working and sharing with clients

See also in file on need and file on needs assessment

dn 2505

Antecedents attributes

Assessment involves two people
A Nurse can perceive a patient's needs but a patient may consider their needs as being quite different from the professional's perception of that person's needs.

Differing perceptions of need (whose need is it anyway need s what the clients say it is)
We leave Care Plans in the patient's home
supposed to include the patient in planning their care
so that there isn't a clash in the perception of needs,
A Nurse may go in and assess the patient as they think the person's needs are
That may not be what the patient want at all

Consequences and Processes outcomes.

dn 2605 Working and sharing with clients
Share with clients
occasionally patients fill in the records which is very helpful

Potential Outcome of working and sharing with clients
Self assessment
palliative care client records pain or sickness record time type all factors it's very useful
that's the only time I've asked them to keep a record it just happens to be in palliative care.

Outcome of self assessment
gives patients say in their care Something more structured that palliative
Patients giving you the information it's a more **accurate record** better way of measuring
Creates **A different relationship with the patient**
More like joint care, because of patient envolvement
If the outcome is joint care, it would depend on the patient, it needn't depend on the care.
Involving some people might be a little more like **co-operative** with treatment as well.
approach particularly developed in palliative care

Appendix 6N - Table 4a

Concept of Knowledge and provision of services.
Health visitors

Attributes / antecedents / Conditions

Relationship between assessment and services
Principles
hope assessment ties in with what the health service offers
Assessment must be **linked to service** otherwise it is meaningless to assessment if practitioners are nor going to do anything in your profession.

Preparation for practice How and where knowledge was gained

Practice
Drawn from previous knowledge of community work
learnt on practice placement as opposed to in college
sufficient space in course practice placement to enable learning
encouraged to visit spend time in places for referral of clients
learning directed by student and in partnership with the CPT.
CPT. field work, the library, allocated time, travel around area
just gradually picking it up in working and talking to other people.
be resourceful self directed learning seen as better
talking and working in community
seen as **best way to learn**

College
Various groups came in to talk to us about it in college quite a number came in,
we were also provided with a number of booklets
Directory of voluntary agencies A - Z
Booklets produced by voluntary and statutory services
practitioners need knowledge prior to recommending services to clients
Cultural specific information required and Varied
Knowing where to go to ask for help

Learning Resources
Written information indicating a mixed economy of care
Social Services provide a **directory**
Family Link which, they provide Children North East **charitable organisation,** and they provide **volunteers to support parents**
annual report about Children's Health National Children's HomeCommunity projects provide information about what's available in the community.

Consequences and outcomes

Unmet need

Worst thing **play groups nursery places**, but then that's **a national need**
play groups have been reduced in this area because of funding, its terrible.
Unable to meet need happens in HV unable to meet needs for services in an area
we do uncover needs we can't meet
variation on how things are received.
Some are resigned think problems are intractable
Some get quite angry and impatient. feel there ought to be services

some blame the system rather than the HV
infer "what else can you expect of the NHS" as an excuse.

Mechanisms dealing with "unmet" need where services are not available

Inform Managers the GP they have the budgets they decide what need is met.
told clients to get in touch with the local counsellors,

Encourage Client power to be vocal is much more effective to do it themselves
write in support
For Practitioners
encourage provision, find help temporarily
important to be aware of limitations
Support clients alleviate situation in some way
concerned not to take on things where there is no other agency
responsibility not to just take over the client

Meeting need clients
there's always somewhere, or somebody to go To Or something available
community development worker, encouraged people to write and protest
Not experienced unmet need
there's a lot of services available. Sometimes there's a waiting list, most of the time you can

Appendix 6N - Table 4b

Knowledge and provision of service responses
N dn 2605

Attributes and antecedents

Elements in the provision of services
2505
Identifying need and Unmet need
Chiropody, Assessed need for chiropody but no service response to meet need
unmet need seems to be a feature of this area we have a fairly elderly population
Some people cannot afford private Chiropodist so there is still quite a need for it depends on the individual's finances aren't enough Chiropodists employed by NHS Service.

2305
A paradox differing ideology Comparative need/ individual need
Issue in meeting individual need and the need for uniformity
There's an individuality about assessment and choice but when it comes to the end
people are still looking for a uniform service they think it's unfair otherwise

dn 2505
Need and resource provision.
Generally what the clients want it's still determined by the resources
2605
Responsive services
Services responsive to clients needs are hit and miss thing
doesn't matter what the client needs are its about what's available still occurs
In some cases clients get what is available only within limited resources just not there any more
There are important services gaps Constraints always come from financial resources
bathing housework etc.,., Clients still see bathing as a nursing duty.

2605
Mixed economy of care service provision (View with joint working)
2305
private care has to be paid for suggest to them to put in for other allowances
Not all people are eligible for Attendance Allowancewithout the money they can't pay

You look to voluntary agencies that are around for money to pay for the service need.
We could use private agencies but I have not done
because you need to go through the Social Worker to get the help
They'd want to know recommended agencies to look at other possible helpers like friends
Cost is a major figure in determining what client's are getting
2505
Mixed economy of care
Where there is an identified a need and no service there isn't enough money to provide
what the client wants,
I know to tap voluntary agencies charitable organisations if one cannot
provide for the need from the normal providers

Ethics and politics of service provision
2605 2505 Rationing
There are areas where the service provision isn't made and it ought to be
Example, Marie Curie Nurses
night sit with terminally ill patients available about two or three nights a week determined by cost not by the clients need
2405

District Nurses fill in some of the gaps having to make judgements it's very hard to judge exactly how long somebody's going to need the care.

2605
Consequences and Outcomes
2405
A hit and miss
Definitely services available given to the patient, rather than what the patient wants are
services rigid and not always appropriate
recently more leeway to use different services beneficial to the patient.
2405
Meeting needs being honest Fitting patients needs into the services.
not being able to meet client's needs deal with it we talked about honesty
care is supposed to respond to client's needs but it doesn't work that way
if patient's needs don't fit into a certain category and sometimes there's a problem with actually meeting a need.
2405
Outcomes
It perhaps gets met but not, not in the best way possible.

2405
Trust procedures in Accessing available services
mainly through the budget holder, the team leader at Social Services, who you ring
Not flexible, **See also working together**
Social Services have written guidelines
you don't get a chance as to which service would be more appropriate to the Client

2505 DN
Creating and Seeking service responsiveness Responding to demands
I haven't said to my Manager so perhaps I'm at fault in not having passed that information to my Locality Manager. I suppose she feeds it upward.
we have monthly Locality Meetings
Services Requested by different clients, suggest it to the Managers about us starting this off"
If the money is there I think they're quite receptive to new ideas.
They ask for ideas of things requests they will consider

2305 DN
There is No formal mechanism to do this **as an individual**,
like a profile that you take to the Management I haven't, done that not as yet
There are huge gaps between things we assess and the services that are provided
Cost is a major figure in determining what client's are saying they need

2605
clients responses to needs that cannot be met
happened several times since I started here
Without exception clients understand "it's a shame but it's OK"
People are aware about the limited resources in the Health Service.
more understanding about limited nursing services than the limited resources in Social Services,
people perceive Nurses as being overworked

NB (Blocks in meeting clients needs)
2305 dn
Different rules and different areas where's the fairness

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They should have access to the same (Example)Special beds
Somebody falls within the different catchment area, can't have it.
Unless they buy one themselves or raise funds to get [?]
"Paid enough throughout my life, why do I have to pay now",

2305 DN
Restricted work practices loss of autonomy (See working together file)
everything **comes down to cost restricts responsiveness**
Change in how we justify things justify through the outcome
whatever tests you did now you have to justify the cost. on investigations to GP's
2305 DN
Fundholding and service provision
positive discrimination for fund holders so where is the choice for the people not fund holders.

Ethics and the reality of what is occurring Who pays
2305 DN
Like any business, if they have to make a profit they will cut corners, trim edges
If,the Health Authorities have to make a profit things (equipment)will go
Major discrepancies in who pays and how things are paid for
Example Trust will be the incontinence pads because when they realise how much money spent on incontinence some Health Authorities, patients don't get incontinence pads.
In the south Patients **buy directly** from manufacturer with **Attendance Allowance**
Up here clients don't get the Attendance Allowance They don't get it as a matter of course.
some **people abuse** of services you provide,

2305 DN
Ethical awareness in not meeting clients' needs Processes involved
Rationing or no services encouraging a mixed economy of care
Usually clients are disappointment and frustration
you sit down with clients majority understand you tell them about alternative services.
Or a list of private services if they're willing to pay.
encourage to make a complaint to the Health Authority, to the Trust,
complaints requests for a particular service then maybes we will get that service

Education for provision of services.

Provision of services for patients
2405
I don't think it could be done in College because each area is so different and has different
Course did not prepare academically about services and provision
2505
Learned mainly through been employed here and throughout my course during the practice placement part of the course. During **taught practice and supervised practice**
2405
How learning occurs about services in practice
Through **experience** of them, **talking to the patients** who actually have the services
getting their ideas and feelings about the service
Practice meet providers, people at Social Services, the Crossroads Carers
actually finding out what, what they did for people.
actually meeting those people. Was valuable
Mainly **the practice teacher arranged that undertaken** in practice
Its out of an inability to meet some needs that you learn more

Theoretical underpinnings
(course) **2505**emphasis on the need for multi disciplinary communication necessary to be tapped to provide of the care to contact the actual services
2605

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There are huge gaps between things we assess and the services that are provided

Appendix 6N - Table 5a

Needs assessment beyond the individual level
Collective needs assessment

Attributes/Antecedents Definitions essential characteristics examples

Defined
A wider view of NA. see community needs of a population as a whole a wider view of NA
Needs assessment beyond the individual level not occurring formally in most trusts
Where occurring they takes on various s forms

Different forms
formal, informal, and intuitive,

Formal
occurring through statistical approaches of existing data, an illness model undertaken on some case loads and in some trusts on the needs of the locality, quantifies conditions levels of diagnosed illness and disability
HV profiling part of the marketing strategy
HV records viewed as in adequate
Hv role identified as work with the under five's

Informal
doing profiles on their own case loads combine intuitive and formal, findings rooted in reality.

Intuitive
classified as "other health needs" within case loads known health needs i.e. youth single young mothers, smoking, and mental illness encompasses social conditions

Reality
professionals are doing their own an uncoordinated approach
profile of particular needs assessment i.e. vulnerability high dependency criteria high risk these have differing definitions use of frameworks from other trusts
currently all differ in their approach

The way forward
(profiling) Assessment of health needs Needs to be undertaken on a multiprofessional and inter professional and involve the clients

Different levels and composition of profiles

Case load profiles
Professionally determined **Separateness**
purpose to prioritise needs plan work additionally uses a sixth sense get a feel for things know when something does not seem right helps practitioners to see the whole picture
Outcome
Twofold gives view of the area and specific clients individual needs and wider needs The whole case load need helps practitioner to stand back

General practice profiles based on the patients/ clients of the group practice
Beginning to be undertaken on the patients in the practice based mainly on an disease model drawing from statistics and the disease ratio of patients. Health visitors profile is a part of or an integral part of that profile

ideal situation. **Combines profiles from differing professionals.**

Trust level profiles

Wider whole neighbour hood based on primarily statistics census inf. medical health model beginning to be instigated or requested but no model proposed as yet very much told to do them by the trust separateness between management and practitioners.

Consequences

Work is based on assessed need more appropriate way to determine work than a case load number approach

provides a **provider profile** but **will the purchasers accept it** and use it

Used by management to see what work HVs are doing and not about what needs are assessed.

can determine future health needs

Should be linked with provision not so at the moment unsure of it being linked.

Informs management about differences in practices

High and low levels of dependency vulnerability risk groups

case load numbers are not an indicator of need but that's how managers allocate HVs so managers do not view our work in terms of health need but see it as doing the surveillance that's what we are paid to do GPs view us that way.

Ideal cases documented as occurring

Two models

community development approach

Involves primarily the clients multiple practitioners and professionals outreach workers meetings held in clients homes housing finance community related.

Social model client centred skill based determined by people's expressed needs based on what people ask for centred around the client's view of need

Reality

a community development approach, deprived estate lot of needs improving the local populations health needs, if unearthed these needs, we find that there aren't the resources to meet them we are going to look a bit silly

Demands of existing role of health visitting,blocks and prevents us the traditional view of health visiting thwarts growth

"As health visitors We only scratch the surface of need"

Primary health care model

gathers information from multiple professionals and practitioners and clients community people librarian health promotion .

based on the provision of health services with regard to appropriateness suitability facilities provision of services access equipment concerned with improvement off existing services in order to change the practitioners approach and provide a more client centred approach.

Appendix 6N - Table 5b

Collective needs assessment Dimensions and skills

Multiple levels of profilling occurring

Attributed antecedents

2505 2605 2405 2305

Community Profile as coursework assessment, **College**
raise awareness of needs, facilities, the environment in which people live.

dn 2405

we did a joint comm profile with HVs pooling knowledge was very valuable.
purpose Holistic Wider assessment of health needs assessment

dn 2605 2505

Caseload work profile

not requiredor asked formally by the Trust Not involved in caseload profiling
Managers collect monthly figures put forward to purchasers so they can actually see what our caseload shows what we do.How many assessed, referred to Social Services,received services a rough figure doesn't really mean a great deal..
They collate what we do not what health needs we actually found.
We don't look at identifying need to undertake nursing work or particular services that clients
They want the difference between what we can actually provide and what they ideally would need Huge gaps between things we assess and the services that are provided

2505

We **categorise work** daily, ages how many injections dressings supervisory visits chronic visits and care need computer information sent weekly to Trust's Headquarters We get a print

Locality / Trust health needs assessment

dn 2605 2505

Locality profile Not required by the Trust no involvement
2505 Audit currently on how many patients have pressure sores, or incontinence

dn 2405

Locality Community Profile (link with assess needs)
DNs and HV's were asked to Develop Health Promotion needs and strategies in setting up initiatives,in response to the Health Authority. Will they inform your work
Before we could think about initiatives, needed to look at the comm profile (not started yet).
To see areas covered by Health Promotion anything missing, of important to practice here.
2305 Locality Profile statistical Public Health data.information that should be published this year. did not consult the clients or the patients in the area

General practice Health needs Assessments

2305 GP Practice profile as the areas differ so drastically
Gives you a good grounding of the pitfalls and what's available,

2505

Structured Formal assessment of health needs Elderly GP's age screening
sometimes delegated the DN time consuming, extra burden assessment took an hour
Currently on hold. GP decided as unnecessary
Needs identified but no services made available

Ward Needs Assessment

dn 2605

different from the day to day work we undertake.
I've looked at the **Ward Profile** in which the clinic is situated haven't studied it properly
Ward Profile different from daily caseload and GP's and neighbourhood Profile

Ward Profile covers, not just our area it covers neighbouring villages we visit
Ward Profiles are generalised everything comes together. Indicates levels of health and poverty in an area. Doesn't consider differing needs of one village from another
Ward profiles are not specific as villages where a high elderly population is evident figures are actually not available.
dn 2605
Ward statistical data collected in the census.
Channel resources into certain areas of deprivation clearly aware of Ward profiling.
It's about **determining services** assess need for the future agreement providing services

Intutitive health needs assessmment
2505sector of the population would like to give up smoking that's an outstanding need to me
other parts of the country DNs run Stop Smoking self help groups
Not involved in doing HP groups in district nursing yet, my
(Joint midwife district nurse post) My Midwifery role predominantly educational it's what you should be doing anyway all the time.
2305
Intuitive needs assessment unmet need
young disabled living on their own patients with multiple sclerosis fifty age group or younger.
no clubs cared for by carers, nurses go in on a needs basis,
young disabled need more backup. because they're young they're expected to get on and cope

Purpose of the profile Outcomes, Awareness, relevance
dn 2405 Gain insight into actual health needs of patients family and population, spend the more time on that priority and the area
different areas different effect on the individual Need to be clear about the resources
Mainly to influence the PHC team as to what was required in the way of health needs.
I haven't as yet thought about any of the wider implications -

dn 2405 The connection profile and practice traditional community visiting
Hardest thing is persuading team colleagues who have not done any academic work who don't see need important relevance or the relationship of a Community Profile to their day today work or its influences on the patient and the family
They don't know what to do with the findings

Reality Outcomes Consequences

2305dn 2605
Case load assessment
Ratio of staffing caseloads geographical areas not uniform .
Grading not uniform discrepancy based on patient population
Based often on GP practice populations not really fair as more patients in urban areas
Managers need to know the different geographical areas locality
Comcare the computer supposed to monitor and analyse but nothing's come back or about.
Comcare does formalise the way we identify unmet need as well as met need,
Data from our computer system Comcare for logging all calls
It was up to managers to go through the data again and see what was wanted.

Purpose of profile
2305 Identify where are the health needs assessment
Overview social classes financial status's of the people life housing likely to effect the health.
Profiling caseload help prioritise, work influenced by priorities depends on staff geography

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Retrospective versus prospective health needs assessment
More a profile of work done rather than a profile of the health needs
2505a profile actually work a list of the work done in retrospect
Dosen't provide for health needs. it's a different way
Interesting to know if they use that info as the base of how they organise the services ...
that's partly the aim of it in the first place. the Government wanted these figures
presumably to know how they could better cater for the health needs of the nation
Its not how it's working. I'm not sure how it works in practice

2305
Outcomes / Ideology
Identify overall health problems specifically comes from the statistics health issue for your area
Health problems addressed through Health Promotion and Public Health
2505
The ethics/ Politics of Unmet need whose responsibility ?responsive services
needs not being met within the services that are available filtered back to the Locality Manager
2505
Reality Exampes
Identification of needs not translated back into the provision of a service
GPs Elderly screening by some DNs results fed back, assessment found need for Chiropody
I take it back to the GP,he ought to feed it back up, need ought to be catered for
Needs identified individually in visiting patients Hidden needs services not developed in
response to those assessments, Two identified needs for service, we have waiting lists bathing
and chiropidist Profiles do not identify the Chiropody or bathing Needs
Problem with the system,need verbally fed back to managers, and GP's. we dont document it.
don't know whether it gets fed back up, it doesn't seem to connect up.
We should become more pushy, haven't pushed Management to provide,there isn't the money
dn 2405 Don't have time to spend sitting down and looking into area health needs
Not always time to think, what to prioritise done more on the go, comes into day to day work.
Since the course haven't undertake anything on paper.

Reality ethics and politics in meeting need
Insufficient meeting of need, working togetherness, rationing services

dn 2605 Areas where the **service provision** isn't made and it ought to me
example, terminally ill care needs not determined by the clients need
cost is a major figure determiningwhat client's need

2305The gaps, unmet health needs not fed into that Locality Profile
Main unmet need probably social care probably the same unmet need for years and unless you
actually tackle it will remain unmet.
Information given to the Manager comments particular gaps needs comment recognised patterns
2305 Manager Fundholders won't pay for staff extra hours not used to
paying for it and to be quantified in that way they've only been fundholders, for a while

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Appendix 6N - Table 6a

Joint working collaborative working interagency working
HEALTH VISITORS
Attributed / antecedents / conditions

Occurs to some degree only in working with child protection
Biggest involvement with **social services**
HV opinions and judgements are being valued more so by social workers, seen as being more holistic still some **old attitudes** remain towards health visitors.
important historical perspective why the situation on need to work tog had arisen
pertinent to how the management structure of the area and how it has impacts on work tog

Social workers work very differently from HVs
Social workers much more formal ways planned ways of working, visit when they are ready to visit HVs don't work that way say they will visit in a week or so, only respond when they are ready to respond.
set in a legal framework more formal, more complex documentation
determined and guided by certain procedures, purposeful more legally responsible
More difficult to work with **social workers**.

Role for routine health visiting a way of **getting into** assess need
involves **talking to people building up a relationship.**
They wouldn't come to you if you hadn't done that groundwork first.After that
People come knocking on the door, large part of work has been **crisis visiting**

More **difficult** to get to know the social workers
Structural changes occurring in the social services
Practitioners main link with SS is in making referrals
poor communication no feed back, lack of personal contact, anonymous contacts, no named person

Working with **other professionals** important issue as we draw on **multiple expertise** in assessing and meeting need
All professionals **share same concerns** and **expertise** about need able to point things out to others

Working with GPs is different, depends on the opportunity to discuss, important to work with GP as they can provide relevant information.They do the referring
Need to work more cooperatively

Consequences and outcomes

In assessment Two types of assessment occurring, professionals and social workers
Multiple assessment occurring
no joint assessment occurring
duplication and over assessing many assessing all using their own documentation
working jointly not occurring
working very separately
Different professionals different ways of dealing with the issue
Not appropriate for the clients
Difficulties working with social workers
not so with other professionals i.e. Midwives
GPs appear distant

Paradox

Different ideologies different approaches different agendas different masters constraints conflict lack of knowledge of roles
Separateness yet professionals **share the same goal that of Meeting client need**

Separateness on issues **Hinders** joint working Hinders development and meeting need
Feel **divided** in meeting expressed need of clients
Trust determine our role and responsibility
GPs determine our role and responsibilities
GPs work differently medical model treatable presenting obvious expressed needs, not the wider health needs
GPs work with targets and what they are paid for
HV marketing documents Coopers and Lybrand determine our role and responsibilities
Thwarts development and community development approaches.Conflicts with meeting the community health needs

Educational needs from data
concept of working in partnership
we had one session about working in partnership.

interdisciplinary teaching
core with District Nurses and Health Visitors
not aware of other professions undertaking a similar sort of course
social workers doing their courses on the same floor

Inter disciplinary teaching and interdisciplinary working
would enhance joint working knowing need to know their approach,
Social Services Department approach is different as a generalisation
we both have expertise and different approach

Inter disciplinary learning and working NHs Trusts once qualified
we attend multidisciplinary induction courses in Child Protection, The trusts valuable, people from Social Services, School Staff, Probation Officers, Police, altogether only in Child Protection
useful important obvious need for working together
various groups work together for example in case conferences
Important to work tog in that kind of problem.

example Ideal Case
Special Needs Team in the area psychologists doing their assessments in the Community
Much more into multi disciplined work

Appendix 6N - Table 6b

Joint collaborative multidisciplinary working
View with care management file
2305
Attributes Antecedents

Joint working
2305 not occurring no collaboration between Social Services and Health.
DNs seem as if we're out on a limb,
there's us and them and we're not working together principles right reality different

Joint assessments
2305 2605 2505 2405 There is no joint assessment here,

Nursing assessments
2305 2405 2505 2605
District Nurses still doing our assessment combining our nursing assessment

Constraints to joint working

Structural
2305 Director of Care Managers (He) does not want District Nurses involved in this assessment.
sees it as a Social Work prerogative does not want us invading their territory
gives you some indication of why we don't work together
this is a Management thing nursing Managers aren't strong enough
Managers who just won't listen, needs sorting out from the top down.
there's nothing we can do.

Territorialism Thwarts to progress
2305 Control from the top Kept in their place
Intransigence managers lack of progress

Financial
2305 lot of wasted money if we work together we'll probably save thousands

Responsibility
2305 No one person take responsibility for that individual client, or patient in Social Services it's just a person on a desk at Customer Services, which is not working

Multi and inter disciplinary approaches
2305 Too much inconsistency, you can't work as a team, Managers have to provide this
2305 2605 Overlapping roles, duplicity, filling in, limitations multiple assessments

Interdisciplinry constraints
Ideologies perceptions
26052305 Social workers have no concept of health philosophy is different they have different training
don't look at the same problems in the same way, we have completely different ideas.
2605 2305 Different priorities, different Standards Different expectations Not always agree with
what they do
we're not always familiar with the services and what they actually provide.

Role Differences communication
2305 Social Services won't work with us, they're blocking us we just seem as if **we're stuck**
difficult to access, refer on, wait for appointment put on waiting list nine month waiting list

Deal only with social needs we have to fill in the gaps at weekends
People expecting Social Workers to do things waiting list to see a Social Worker

Communication constraints
2305 2405 2605 No collaboration between the services
We don't have team meetings we never meet up, we never see each other
Problems of communication with professionals
2605 have to refer for second assessment
Historical thing not something that we're going to be able to sort out ourselves.
creating new services clients or nurses not informed not knowing what's happening
2605 work at a distance with social workers

Access Barriers
2505 2605 2305 Putting more barriers to access services, the individuals access social workers go through "Customer Services", at the end of the telephone or have go back to care manager

Duplication of assessments
2305 2505 260 2405 We are still doing our traditional, single professional assessment we stumbling on assessments
we only have our own documentation,

Documentation "Shared"
Never seen Social Services documentation for Care Management assessment
no experience of it in practice College either We were never shown any of it then.

Intra professional difficulties
2305 2605 2505 Hospital staff don't know how it works in the community, no community knowledge
Many don't have any inkling as to what we do or how we do it.

Principles Reality Dissonance
2305 2605 IN principle all supposed to work together for the benefit of the patient
goals were unrealistic, they didn't take on individual problems of communication,
Belief in ideology Soured with reality Concepts part of "needs assessment" are not occurring
About taking responsibility

Consequences and outcomes.

Awareness and access for the clients
Clients supposed to have choice of host and services
Reality is impossible to realise you cannot fund all of them

The effects of Boundaries and boarders on care of people.
different Social Services have different workers and services available
differences affects clients who live on the same street

Policy changes impact on District nurses and nursing
Hospitals now rule that the money will firstly come up front from the GP.

Fundholding
Loss of autonomy ,Impacts on decision making and Judgement
2405 fundholders constrains, loss of autonomy
2605 2505 2405 changing role great deal of influence Need to be more inflexible
2605 2505 We have to do develop more skills and knowledge
now attached to fundholders s geographically
2305 2605 2505 develop your work and your knowledge responsibility really
2305 Preventative care Ask permission not valuing professional judgement

Funding impacts on the types of dressings and diagnostic swabs you use you may do, Practitioners do not know the costs or what the budget is anyway
2605 working more closely with GP's
consulting them about what they expect of District Nurses

Some solutions

Intra professional issues

2305 Going around in circles Hospital staff no knowledge or experience of community whereas all community staff have experienced hosp work

Education needs for the future seen as major need

intra and inter professional education initiatives.
An Integrated Interlinking Incremental interdisciplinary educational programme
2305 Uniform training generic training education skills. Things won't work until then.
2305 2605 compulsory continual updating of training, educational and services
reciprocal observation experience between Community Nurses and community Nurses Just as joint meetings but meetings are quite costly in time and money
2305 Inequality of opportunity Consider people's tendency to train
2606 learning to trust and being educated to togather
Education on going
2605 make people more, "co-operative" co operatives the wrong word, more understanding of the other's role it would need to be reinforced

Future Preparation of practitioners in working together

Facilitating working together Solutions
2305 Acknowledging a cause of the current problems
good collaboration between all the services in Community Care
communication channel between the two services.
2605 2305 2406 meetings, see each other training students in the Community get a birds view
2305 knowing each other you can work well with Individuals you know
2305 2605 2505 just no personal contact only phone never see them
2305 Knowledge of professionals roles and responsibilities
We're not au fait with what each other does or what we can provide.

Curriculum document

A common core approach to shared learning currently occurs at an intra professional level between DN and HV despite the social work course being run in the same department. Emphasis on learning through experience, group work problem solving and project work threaded through the core and professional subjects was evident, facilitated through student centred learning.
Evidence from the data supports the curriculum emphasis on practitioners ability to work together, encouraging common understanding of each other's role. Emphasis on individuality partnership collaboration team skills leadership through many modules supports practitioners beliefs expressed in the data views. These skills and knowledge were highlighted clearly by practitioners in the data as essential in effective working with clients individually and in groups. There appears to be a need to facilitate practitioners in transferring and making

the link between knowledges and skills in working with clients and working with professionals.
Befiefs about the holistic nature of need needs assessment and clients centred needs led approaches was expressed by all practitioners. Beliefs which apppear to essentially guide the work of community nurses do not appear to supported by any theoretical learning. This was highlighted by practitioners and supported by the absence of explicit theoretical foundation in the document.

Proposals
The framework philosophy transferred into working with other professionals is necessary in broadening the shared core elements with other professionals. This needs to occur over and above intra professionally level and embrace other professionals in working effectively with other agencies involved in the delivery of community care.

Related and supporting literature

see additional literature in the commentry folder stored with the final concepts of the district nurses.

See working papers on collaboratice working joint working ete.,
See Wiles and Robinson 1994 Journal of Advanced Nursing. 20, 324 330
on teamwork in Primary Care differences in the views of DNs HVs Midwives

Examining multi-disciplinary working in child protection **Murphy (1995)** proposes that structural blocks to multidisciplinary work stems from differences between professionals and agencies. These naturally occurring differences disunite disciplines and agencies and appear to be located in the professionals differing
Perspectives,
Role,
Steriotyping,
Priority,
Training,
Structure and power,
Language
Traditional ways of working
Hypothesis proposed by Murphy supports practitioners views of current experiences in working together in needs assessment. Good multi disciplinary working thought difficult to achieve begins with effective communication moving through mutual planning, co-ordinated action and constructive review.

Carpenter (1995) Indicates that collaboraive teamwork would be enhanced by fostering positive steriotypes and reports changes in attitudes to other professions and diminished negative steriotyping during shared learning in interprofessional education.

Barr, H. (1994) Indicates that the dicotomy which exists between Policy characterised by separation and a ideology for professionals to work collaboratively in an integrated fashion has contractitory messages for joint training initiatives. It appears that no one approach to shared learning would be adequate in developing a creative and adaptable workforce. This view is supported by Davidson and Lucus (1995) in believing that students who experience shared learning will emerge with skills to promote working in multiprofessiona teams

Shaw I (199?) Viewes joint training as an important part of the process of enhancing the inter-professional collaboration seen as essential for the effective execution of Community care iniatives

Barr, H. 1994 Perspectives on shared learning London, CAIPE

Carpenter, J. 1995 Doctors and Nurses: Steriotypes and steriotype change in inter professional education. **Journal of Interprofessional Care 9, 2, 151-161.**

Davidson, L & Lucus, J (1995) Multiprofessional education in the undergraduate health professional curriculum: observations from Adelaide, Linkoping and Salford. Journal of **Interprofessional Care 9, 2, 163-176.**

Murphy, M.1995 Working together in child protecton. **An exploation of the multi-disciplinary task and system.** Arena, London.

Shaw, I. (199?). Learning together- Social work and Nursing. Health &Social Care 1: pp 255-262-

Appendix 6N - Table 7a

Community care Act
Concept from the data.Health Visitors.

Anticedents /Attributes / Conditions

Comm Care Act not related to HV work Not in general, not in individual role of HV not really applicable to Health visitor's clients
Needs assessment and hv assessments being undertaken both types of assessment compliments each other they go together. HV asessment less formal but and extension of the and in tune with the CCA

Elements of the CCA
care should be within the community whenever possible.
Government wants health care to be community based
agencies working together.

Interagency work
with Social Services particularly in child protection
Work with other agencies education, special schools,teachers,nursery liaison work,

Not specifically see joint assessment as part of the Community Care Act
Joint assessment are about learning all the needs and the care given to that particular family,

Multi disciplinary assessments much needed
but not really occurring as yet
Hope, **both types of assessment** will continue to go on You know, that's important.
experienced needs assessment undertaken by other groups of professionals

Documentation associated with the CCA is more formal and longer and more involved
Much more indepth assessment of the family

previous knowledge
Yes school nursing background, familiarisation with like the Children Act.

Education in college
I think I've just picked it up along the way really.
Not specifically, taught or learned in the course work no.

the Community Care Act, the NHS and Community Care Act.
not learned a lot .
just that it was a new Government report we needed to be aware of it
more focus on care in the community
community nurses would be responsible for assessment of families
we would have more responsibility for that strategic shift
money coming out from the acute sector into community units
would mean more emphasis placed on community services.

CCA Learned through
Reading once we got into College the TV
it was very much an issue, a matter of making use of it,
general articles

Teaching sessions as well and **discussion.**
Not terribly well done in college

no joint assessment, joint recording Working with Social Services were mentioned and effectiveness about the idea of working together with Social Services people feel everybody has to help their own little bit
learn the theory only in college
in practice it becomes a reality

Disadvantages in lecturers teaching needs assessment
people teaching who hadn't been out in the Community a long time
Tended to take everything from the NHS Management Executive they were a bit sceptical.
Took time to grasp it, at times it was terribly woolly and vague particularly without having all the primary care mechanisms in place including the preventative approaches

Knowledge learned in college and previously as a District Nurse.
Consequences / Outcomes
Ethics of meet a clients needs.
It concerns me that we are going to uncover needs which
we aren't able to meet through lack of resources, worries
we unearthed these needs, we find the resources are not there to meet them, looks a bit silly
Community development approach lots health visitors could do

The way forward
Reality Move to **more a care based workload**
Case load maagement
Through **Care Management in practice** now aware of the restraints.
Role of the Hv increased within the Act The change of role with home helps you're providing housework care,

example Ideal Case
Special Needs Team in the area psychologists doing their assessments in the Community
Much more into multi disciplined work
not part of the experience not seen the records of those assessments?
we simply get minutes of the meetings with each other
not directly involved with it nor asked to undertake an assessment
I did a joint assessment with a Dietitian in a study children study of fifteen year olds which was particularly interesting.

Educational Needs for Community care Act
Education in college
I think I've just picked it up along the way really.
Not specifically, in the course work no.
previous knowledge
Yes school nursing background, familiarisation with like the Children Act.

Comm Care Act Learned through
College

Knowledge learned in college and previously as a District Nurse. learn the theory only in Colleg In our practice it becomes a reality

Teaching sessions and **discussions. reading literature and the TV**
Not terribly well done in college
no joint assessment, joint recording Working with Social Services were mentioned and effectiveness about the idea of working together with Social Services people feel everybody has to help their own little bit

Disadvantages
people teaching who hadn't been out in the Community a long time

Tended to take everything from the NHS Management Executive they were a bit sceptical. it did take a bit to get hold of it at the time terribly woolly and vague particularly without having all the primary care mechanisms in place including the preventative approaches

Review of the literature
The community care act 1990
Embrace rather than segregrate the outsiders the enemy
The act accelerated the need for unification in needs assessment through the **enforced role changes** for patients and nurses and doctors.ways of new ways of working in needsassessmnet
Working for patients
the transformation of from the passive patient receiver of professionally determined needs and services.to consumer as client with the power of choice and affiliation of professionals
Discrepeccies in how people view efficiency a differing concept

Appendix 6N - Table 7b

The Community care Act (District nurses)
N Final compilation of data elements relating to the Community Care Act

Quote "The Community Care Act, it's not something that sticks in my mind."

Attributes antecedents

2505 2305
Background to the Act
The Governments Community Care Act
Government instigating the Act,
Community Care Act developed to support people in their homes for as long as possible
2505 Community Care act going to be implemented in April 1994
course was 1993 - 1994 so we were **certainly told of it**

Elements of the CCA
2305 **dn 2505 Joint working collaboration and working together**
Hardest thing different philosophies different training different ideas.
need for preparation.
need to work as one team, **multidisciplinary approach,**
2505
Community Care Act, and Needs Assessment
Care Management to help provide seamless care (use that jargon word)
provide more efficient and effective care, avoid the bureaucracy.
process to enable **Communications and teamwork to** occur
to exchange ideas, to communicate, to work together
2505 Community Care Plan locally produced, the Trust FHSA

2605 Philosophy
Compulsory that people live independently as possible in their own homes
Carers needs should be considered
people encouraged to use their own resources
to make that happen rather than statutory services all the time.
Social Services would take the **lead role in Community Care.**
2605 Resources,
Knowledge of resources available how to initiate things,
We were taught about the Community Care Act in College
was mentioned we didn't have a great deal on it, it

Education for the Community care Act
Theoretical underpinnings
2305
I don't think I can remember some of the main elements
learned through an assignment
personal reading The Nursing Journals pick things out of the library
Social Policy in how the Community Care Act influenced that.
College we did a lot about **collaboration and working together**
dn 2505
Unable to recall the theory or principles of the Community Care Act
Referred to rather than being taught specifically we were told that there was this Act
2605
Community Care Act learn in College should be working together, a need for preparation.
we all need to work as one team
2605

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NHS and Community Care Act learnt on DN course

2605 Education
I can't remember learning anything about joint assessment **did not know**
needs assessment and care management were drawn from the CCA Community Care Act I haven't been in this job long enough.

consequences and Outcome
2605
Theory it does sound very good,
without the resources money and the staff, it can't be done.
dn 2505
Act has been interpreted in the Health Authorities used their initiatives as they thought best -
Reality
don't meet **face to face with social workers Social** workers work differently
Don't **meet up and discuss any problems,**
they have different training
Sometimes, different philosophies
carrying out assessment in different ways, focusing on different areas and priorities.
Clients get confused.
2305
District Nurses promote **Independence**
Social workers **just put the services in**
2505 Care management gives us more power

Appendix 6N - Table 8a

Concept of need and needs assessment health visitors

Anticedents / Attributes / Conditions.

Needs assessment (defining)
The needs of the individuals within the wider community needs
They are part of the other

family more than an individual (Concerned with)
Whole family and seeing what their needs, not just health
needs, everything to do with that family whether its social, environmental, everything.

Not only individual also a group situation
particular need expressedwithin a group

Needs assessment (Link with services)
concerned with the ablility to address the need

Holistic approach (practitioners concept of)
holistic means Looking at everything, taking everything as a whole.
you can't look at people individually or focus on a child because you have the mother or father onboard with you before you can achieve anything

Assessment (purposeful activity)
Ongoing process not one-off always linked to service provision
Assessment must be,linked to service Otherwise meaningless
Why assess if you're not going to do anything in your profession.

Needs assessment (Different forms)
Multidisciplinaty assessments
different difference being located with the needs of the client
Different assessment to where the Hvs are only involved in assessing the client needs

Needs assessment (In Health visiting)
Whole basis of health visiting the whole basis of practice Professional assessment
The cornerstone, where you go from there.
health visiting health promotion whole thing

Needs assessments (Home visits)
All home visits are "needs assessment "
referrals from clients, must do primary visits laid down, group work referrals from GPs
collect client information and to assess client coping
High input of familys upport to maintain situation in child protection important that that support continues.
Different in that it wasn't particularly child centred it was centred around the needs of the adult from the family which had repercussions obviously

Needs assessment (by other professionals)
two different "types" of assessment occurring

Social Workers go through this process **to obtain the end result**, wanted from a legal point of view.
HV not got that same involvement,
needs assessment (by Social Services)
Documentation different,
No involvement so far in those needs assessments

needs assessments different to HVs at the moment different documentation,
complex need for services
health visitors don't have the same type of needs assessment.
filling in forms about certain situations
occurring (somewhat different from routine health visitor work)
More complex situations, new cases who would initiate a case conference
Not involved in that situations where 'your assessing parents abilities and coping skills then that's when they would be used.

Joint assessing
not part of the experience not seen the records of those assessments?
we simply get minutes of the meetings with each other
not directly involved with nor asked to undertake a joint assessment

joint assessment with a Dietitian in a research study children study of fifteen year olds which was particularly interesting.

Documentation for needs assessment
structured or non-structured Objective / Subjective
Difficult to separate those things out.

Need to be objective Yet initially non-structured and hopefully move towards structure later.
profession caring and centred on clients need
Concerned with achieving balance between the two

Conditions
depends on **the situation** to some extent.
assessments **all different**
Some situations would be wholly client needs led
others tend more to be resource of policy things
more structured approach where client not well or aware of need

BALANCE
client centred approach
Determined by purpose of assessment
Takes time for clients to take on board whatever it is that they need to do
can't evaluate what's happening too early in the process
it takes more than one visit before you can really say

Unstructured
Prefered. as recording assessment during visit acts as a barrier, seems rude in a clients home
use unstructured approach but uses a " framework in my mind"
go into a house with idea about what I'm hoping to get out
always have mental list of what I want to ask about

Structured
clarifies purpose, problems and client needs requires structure to achieve purpose
Whereas too structured becomes a straight-jacketed can be a bit too structured

"Intuitive" assessment
Assessing needs (Specific conditions) With or without structure
vunerability,for example We dont specifically measure it
key points in vulnerability
the whole set up in the **family situation,**
support, good **partnership,** good **relationship** with partner, other family support
suitable **housing financial** general things
vunerability kind of danger signs means its more needs assessment
vunerable, an awful lot of needs

wider need than just health visiting
Family was in **homeless accommodation**
Mother **learning dificulties.**

Consequences /outcomes

The way forward
Reality Required to Move to more a care based workload
Case load management
Achieved through **Care Management in practice** now aware of the restraints.
Role of the Hv increased within the Act The change of role with home helps you're providing housework care,

Care management Benefits of one person co-ordinating
should lead to better communicationan
improved service for the client.
one person taking the responsibility,

responsive services (linked to that individual's need)
Don't know if services would be more responsive,
perhaps enable things to be done more quickly.
don't see it as being more responsive
we should all be responsive in our own way anyway.as a single profession.approach

How care management can be achieved.
demands on you from the existing case load
need to be free from doing routines assessments.
more flexible going for another reason and at the same time looking at the development of the child at that stage

Educational preparation for assessment
a little in college **mainly it was all on field work**
each visit you would have a set aim for a visit
CPT would always say what she was hoping to achieve at each visit

preparation for assessment
not wholly in the college
drew from previous type of work and experiencewhich helped a lot.
Assessment skills
various teaching sessions on assessment
personal skills, life skills necessary skills in working in sensitive areas,
Skills for carrying out that assessment
theory you need for undertaking assessment
obviously very important to find out the client's view of their needs also
clients may feel quite different to different points
need to discover how they see need and the process of what they feel

Education for assessment in college
just sort of in a child surveillance way
Just going through what was normal development and what you should be looking out for and assessment.using Mary Sheridan.
assess what was going on in **thewhole family** andthe problems of parents
Training helped me to look at the family
whole context the environment they are living in
that has really been the **major thing.**
theory put a label on what I have been doing without perhaps really realising it and helped me focus on how I have been doing things

Elements of needs assessment taught in college

joint assessments was mentioned in passing
that we could be askedto do a joint assessment just with Social Services mainly,
the emphasis was again placed on child protection
it was much with the child, it wasn't looking at adults in the community at all.
Working in partnership with Social Services,

Educational needs for needs assessment

Knowledge of vulnerability,
coming from the course I think, from the training,
Did Not do anything specifically,on vunerability
key factors didn't come in any sort of framework
Use the principles of health Visiting

Preparation for needs assessment

Needs assessment in the course was a bit hit and miss.
Taught by people who could not teach who were thrilled to bits with the jargon, but didn't really know what it meant.
only one or two of the people from the Nursing Department really made one feel that they knew what they were talking about
one lecturer in particular, delightful person but not effective as a lecturer
One lecturer could string all the right words together but it didn't mean anything completely out of context
Its about the people and their knowledge base
If you are going to have a Department in a University you need people who are then able to hold their own in the field I don't think that is how it is
I tend to talk about a degree level University, that's not here, not at the ??

Assessing children (Area of concern for practitioners)

work is predominantly with children
we did **Child development** very briefly in college
it was **picked up was in field work,**
visiting seeing the range of what's normal and picking on the abnormal during your visits.
given **a list of what's normal and what's not normal**
being told how to look for it isn't really enough, you've got to see it and do it
There wasn't enough about children and their development, definitely wasn't enough,
skills, and knowledge of child development,
being **able to see what's normal.**

Subject knowledge for assessment

What was missing

things like public health, special needs more counselling skills

Underlying subject knowledge

psychology definitely one of the **most important** things could have **done with more Sociology, how people are labelled** and how **society views different people**, I think that helped.
professional practice
related to what is different about health visiting
Working to the **principles,** are quite important points of **health visiting.**

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social policy,
law in context of child protection and courts
we didn't really do very much at all on ethics.
Consenquences and outcomes

Concept of holism and Humanism

No education on what **holistic** means
used as a word, the notion of holistic care but not gone into in any depth about it.

Ethics of meet a clients needs.
It concerns me that we are going to uncover needs which
we aren't able to meet through lack of resources, worries
we unearthed these needs, we find the resources are not there to meet them, looks a bit silly
Community development approach lots health visitors could do

Moral basis of care

Political underpinnings of the Act and needs assessment

Resource allocation
Prioritising need
Education for needs assessment from the data
What about the term "Needs Assessment"?
No can't remember needs assessment at all

Literature on needs assessment
Needs assessment
The white papers **Promoting better health**
given greater responsiblities
facilitate new roles and services
new responsiblities.

Appendix 6N - Table 8b

CARE MANAGEMENT (DISTRICT NURSES (N)

Antecedents attributes

2305 dn Care Management and Needs Assessment

Care Manager's needs assessment different to district nurses

More formal assessing what services to put in.

2605 Care Management is different to the work we do now

The policy of care management
Ideology, impact on joint working. "cuts out the middleman"

dn 2505 Government initiative, Assess social and health needs, cuts out second assessment easier to tap resources

2605 patients get them out of the institutionalised setting Vulnerable People those who need help.

dn 2505 Marry Health and Social Services, provide better, more holistic care.

2605 make assessment more client centred

2405 2505 2605 Theory one person responsible for co-ordinating care package, cost effective in organisational time.

2605 Concept of **key worker** Improves co-ordinating Health and Social needs

dn 2305 2505 for some patients not others

The ideology of Care Management

2405" To provide more suitable care which patients are more comfortable with."

2505 One person Organises manages package of care

2505 identification of a need and provision of appropriate service

2405" assessment, be continuous, a free flowing service

2405" based on patient and carer choice

2305 2405 dn work out what patients need give them all the options

2305 services equipment and care ready on discharge

Care Managers

2305 2405 2505 2605 usually Social Workers

Thought District Nurses would be Care Managers, but it's Social Workers

2405 2605 Social workers don't have a Health background as nurses do

2405 2605 theory depends on who has greatest input, determined by client needs i.e. terminally ill.

dn 2505 Determined by social worker, entirely I mean entirely

2606 Assessed by Social Worker Prior to hospitalisation need at discharge

The Social Workers would then like pass it on to liaison

District Nurses as Care Managers
Criteria

2305 Taking a precedent with District Nurses

dn 2505 DN major input to client care

dn 2505 Principle cut out need for referral to a Social Worker, DNs provide Social needs

2405 Useful in terminally ill patient visiting regularly monitor services and changes

Terminally ill patients complex cases Justifies the role of District Nurses in CM

District nurses as Care Managers (Power but no power.)

2505 2305 Greater influence in services provision contract to provide a certain service.

flexible ways of meeting need

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providing care to meet the individual's needs rather than providing a block

Working together in care management Facilitating
2505 2605 Good communication, direct access to both services (currently don't have)
2305 2505 2605 team meetings,
2605 Trusting other professionals **Potential conflict**
Social Services were loathe for nurses to be able to allocate parts of their budget and vice versa
they weren't happy about that idea, of us being able to have a say over their budget
and what is to be spent That attitude and progression? it's about trust really.
Idea[illegible]orld we ought to be able to trust other professionals to be competent in what they spend.

District nurses Preparation for care management
2305 dn
Care Management is different, need to have additional training
don't know yet whether we're responsible for budgeting the cost of the care,
if that's the case then we need additional training as budget holders

Experience of joint training for Care management
2405 Joint training run by Social Services geared to Social Workers as Care Managers,
involvement expected from DNs given grounding in the theory
2605 multidisciplined training actual team from same geographical area
seeing each other face that's an important element of being together.

2505 UN learnt concepts of Care Management from alternative practice joint training in the Trust
The DN course We had a talk from a Nurse Manager.
2405 cm dn
Concept of Care Management belongs to the TRUST NOT learnt in College.

. **Outcomes Consequences**
2305 dn Reality The practice of care management.
It doesn't work patients, are out we don't know Hospital Friday discharges
nurses go in on a weekend.

2305 +2605
How can Social Workers assess Health needs they're not trained in Health

Initially worked reasonably well, now services seems to have disappeared we're not getting the referrals.
Breakdown in communication
Patients are coming out of hospital and unless they bring the letters to the GP's,
we're not finding out they're out and the Hospital's falling down as well
Example pt for terminal care admitted into hospital for respite and died, nobody inform us,
equipment delivered two weeks after she died. We found out from a Home Help.
Inconstancies Discharge problems
2305 2605 Clients not receiving discharge letters they are out for days and we don't know

2305 dn Reality of what is occurring
"Handed" (by the social services)three patients who are to be Care Managed,
previously assessed by SW and just handed over, transferred to me
Initial assessment done, I am responsible for re-assess of their needs *see related literature*

Experience of Care Management
2305 dn Different role to District Nurse at the moment
Care management gives DN's additional responsibilities additional clout and satisfaction
Care Management more power
2505 Gain those resources for the patient
originally I would have referred on.

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Someone else would assessed again, now I simply request one day and the Help is in the next
Colleagues say its very good my two colleagues are already Care Managers

Reality care management
2305 2605 With right resources that was alright, but you can't put the people out in the Community
without the services they need, without the backup they need.
You can't sort of take them out of institutions and put them into the Community and say "Get on with it" which happened to the elderly when they closed Geriatric Hospitals, said oh they'll be
better off at home.

2405 cm dn
Specific inputs for community care New ways of working, specific roles
Rhetoric versus reality
we have Social Services Department especially for Community Care,
there's not enough Care Managers.

Rhetoric versus reality.
2505 2405 2305 2605 No real choice don't always have the choice
Resources still leads that choice
PTS allowed so much a week of respite care within the budget not based on what they need
it's all very carefully worked out (By others)what you can actually have.

2605
Care management is a more efficient way of managing a package of care.
Efficient one key worker person, with greatest input into the care
responsibility for care **more co-ordinated** more as it ought to be.
more efficient way of doing things

2405 cm dn A double edged sword
DN s got the knowledge for the Social care and nursing care
Provides a holistic assessment -needs as a whole and of the carers and provide help
whereas other Care workers don't see the whole picture and just focus on the service,
not the person needs, just to meet maybe one need,

cm dn
Impact of Care management on district nursing work and educ prep
2405 Some district nurses reluctance to be involved
Impacts on the caseload, Additional demands on workload
Not allocated extra time has to be incorporated into daily work and busy caseload
Impact on clients
Hardest thing is not able to meet patient's expectations
demands extra now from carers, overused services, its difficult to compromise
Deal with demanding carers by discussion, being honest
Clients respond to honesty differently. Most respond well Honest is essential
To give all of the facts, options to choose for Clients to decide
Reality Not always a lot of options with the services that's changing a little bit recently.

2405 cm dn
Differences in care management from district nursing work
it's very similar, you still monitoring the care and carry out some care
co-ordinate and monitor **services**, somebody else giving that care
Assessment to assess who is the correct person to be giving the care.
If it's appropriate for carers to undertake the tasks that they're performing
a resource to teach carers ensure things are ok a back-up,
role different in Care Management different to non care managed situations

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Non care managed situations. Duality Working at two levels SS control
2505 District Nurses we're actually giving the hands on care and you're still supervising and teaching supporting the carers, the relatives the patients as well.
2405 cm Restricted being holistic where were doing a little bit of the assessment with SS you're not
allowed to actually look further unless you're actually going to take on the Care Management.

Care management documentation
2405 Documentation is different Social Services Tick boxes adding comments, rigid structure restricts, documentation being revised and revised
2405"The carer's and the patient's views what the actual problem is and not looking further at the
needs recorded on Social Services computer

Criteria Reality of what is occurring (No apparent visible strategy)
2405 Nobody's got the time to take on Care Manager while it's not appropriate.
Tends to be people who are terminally ill and need a lot of our care the more complex

Impact on community nursing POSITIVE
2605 Care Management a logical step particularly the patients with the most complex needs
DN Responsiblity then for Health needs and Social needs.
2405 Hope it leads District Nursing into more of a managing of patient care.
Team leader rather than actually doing the day to day work positive move and outcome for DN's
It needs our skills, uses our skills more fully.

Grasping the nettle
2505 positive step Depends on how it's handled, depends on the District Nurse
can be innovative Develop expertise, opportunity to promote DNs, take on new challenges
"We don't want become a side kick to a doctor"
2605 Care Manager for a couple of patients incorporated into caseload workable.
Will effect our work as initial arrangements / package will depends on the complexity.
Time consuming to assess then set up a package of care co-ordinate the different services for client

NEGATIVE / RESISTANCE
Influence of Care Management on future of District Nurse

Care management in a changing climate resistance versus enabling
2605 cm SOME District Nurses don't want to leave the hands-on care, the day to day work.
feel they'll have nothing else in the role of the District nurse
they won't need perhaps as many of us.
That's a worry they're hanging onto their jobs, whatever it means,

Related Literature.
Practitioners report the recent introduction of care management as a new phenomenon for district nursing. Care managers up until now have always been social workers with practitioners playing a marginal role in needs assessment. Their new role in care management does not appear significantly different, as social workers delegate clients to them for care management. Their role and responsiblities being that of monitoring and re assessment and not of primary assessor. Exceptions to this approach appears to be evolving with clients who are terminally ill and whose needs predominately require district nursing intervention. These finding support The Audit Commission Report (1990) who found "an assumption" among social workers that Care manager equals "social worker." and suggest that nurses are well placed to take on the role as care managers. This assumption by social workers is not unexpected in that local authorities were charged with undertaking the needs assessment in collaboration with other professionals. And that the care manager appointed may not be the

designated person responsible for the assessment and design of the care package (Caring for people 1990).

Audit Commission (1992) The Community Revolution, HMSO, London.

Department of Health (1989) Caring for people, CM. 849. HMSO, London

Appendix 6N - Table 9

Educational issues
Structure Process Content
Health Visitors.

Compilation of content from HV files

Students
we had a great deal of, motivation
How can that be capitalised
Not stretched enough motivation and expectations not met
the rest being specific course content that reflects your practice

Meeting student needs
In college students come from so many different areas
that was quite difficult, people who weren't local, resented the fact that things that we were discussing were based at this site
Fulfilling students needs
difficult initially for students with no previous community experience .
learn as you go along its a learning process all the time.

Do you feel prepared
In some aspects yes,
need the knowledge of a community dietitian
exercise a physiotherapist or aerobics instructor,
need somebody that's got more knowledge

Not feeling prepared
A lot of **students felt that they weren't prepared enough.**
only started to feel confident on supervised practice,
which I suppose is how it should happen
they would have felt happier if they were a bit more confident.

The course gave you the confidence to kind of move forward
certainly made me think about things more
Opened up different sort of viewpoints
Given the theory to be able to look at things more deeply

Necessary skills for assessment
Acquiring Skills for undertaking assessments

Communication and life skills are quite sensitive skills
unsure about learning them in the course, Yet
Need theoretical basis of life skills

Past experience big advantage
familiar to assessing need from a different direction
used to going into the home situation, dealing with people in the community,
dealing with other agencies which was relevant
most skills come from past experience and **adapted** to health visiting.

Skills teaching in the course
Course Underlying theory of the necessary skills for assessment **not provided**
Necessary to have a foundation or theoretical perspective of the skills
difficult to know how it could be provided
at the end of the day you've got to get out there and do it

Skill development in practice
Develop from **practice** out in the field
learn in **partnershipwith CPT** amount of visiting that you do together
acknowledg skills, **build on** previous skills, **adapt** skills where necessary

Relationship between Education and practice
not good if you've had a bad experience in practice
practitioners learn much from people that they are working with,
Individuals learn by example
we all improve as we go along.

Practice experiences
Student experiences very variable unpredictable
CPT's practice as part of the Primary Health Care Team.
Its important to see the CPT's as part of the University too
they were people with great ability
reality I don't think they are seen that way is a great pity

Communication skills and counselling The use of group role play
Different scenarios with **different approachs**
nobody wanted to do it, so the tutors did it.
it was very superficial, It's difficult to try and fit everything in the course

The interrelationship between counselling, skills, and the counselling approach in health visiting work
we are not counsellors.
got to be really careful about what you mean by counselling.
we're listeners and maybe enablers or facilitators, I don't know
Practicising as a counsellor that's so difficult
but we could have done with more
because a lot of the time you are listening and trying to sort of help people see the way out of situations,
more counselling skills would be useful.

Appropriate learning strategies (Dilemmas)
Role playing only in certain situations useful
Students not keen on role play, reluctant to undertake,we opted not to do it
Felt at that time we were very vunerable ourselves
under stress on the course felt that particular time would be very stressful.
inappropriately placed in the course
offered in counselling skills learning
Issues in College Education Course learning and content

Negative learning and teaching
weren't happy with some of the aspects of teaching
some lecturers were not knowledgeable
1 Psychology introduction was taught by recently qualified lecturer terribly insecure
and we complained and the lecturer was changed
2 Teaching lacking in health promotion lectures,
wasn't really good leaning very much how not to do it really.
3 Health Visitor and Nursing theories seen as mechanistic to a certain extent
when dealing with peoples needs and difficulty and need to be make relevant and applied it,
trained before nursing models nurses tend to fit the patient to the model rather than the model to the client the wrong way round and that worries me about the use of the models,

4 Models were taught but over done, important to clarify one's thinking but not to get too hooked on one model but to use as a thinking background

Positive teaching and learning experiences
great deal of difference between being taught by someone who is a specialist in their area students feel much more secure and have access to their knowledge
Another lecturer university standard part-time practising Psychologist immersed in the subject and written books
difference was palpable.
excellent in knowledge essential
Excellent social policy lectures gave us a very wide background, you know very wide reaching. Bradshaw's Maxwell

Bad experiences Teaching sensitive subjects.
we felt very strongly about was teaching counselling,
inevitably people had personal problems
lecturers were completely unaware of individual students problems
close knit group gelled well together supported one another
lectures and discussions on cancer done very badly students exposed to very difficult situations should have been dealt with by someone outside not by the particular lecturer
Stutents should have been protective from that.

Learning outcomes
Not all role modelling is a positive learning experience.
sufficient space in course to enable learning directed student
in partnership with the CPT achievable

Course Structure
counselling skills taugh towards the end at a stressful time people felt vunerable
Important point where specific subjects are taught rescheduling needed
April, May, June most stressful getting assignments waiting for results

Lecturers as past practitioners
Lecturers who taught hadn't practiced health visiting for quite a long time,
examples weren't relevant.
lecturers need to be more connected to practice and practitioner's
Students would feel more secure in their being au fait with things

Preparation for your role as a health visitor?
Is not very adequate really
need less on Health Visitor models
we were fortunate as a group
three of us had excellent CPT's quite outstanding
worked very much together
provided extremely good role models of Health visiting
put together extremely appropriate experiences for us.
learning outcomes were determined by them and us really
Need learning on Screening we need screening
difficult to be prepared for every eventuality

Preparation for practice as health visitor (relevant learning)
we had very little on the important things like breast feeding
whereas we had two sessions on the commercialism of it.

Principles underlying our role as health visitors
Facilitating rather than actually doing it for them.
Need to know where you haven't got the skills.
Ablity to recognise when you haven't got the skills to cope
whatever situation you're in what ever somebody is asking for
Knowing that you can't do and be everything
Able to refer on is so important

Supervision on qualification
the formal mentor was not suitable and didn't work
formal supervision, necessary post qualification to provide fail safe mechanisms for those with difficult caseloads,
Child Protection issues practitioners need to be supported
Need for formal supervision
sorted out our own informal support mechanisms for ourselves.
Reality is practitioners use informal networks

Mentor and Mentorship
Ideally Practitioners should be
able to choose +feel comfortable
same philosophy as the mentor work very well together
ProfessionallyAppropriate mentor
Realistically choosing the mentor not practical
obviously a colleague with more experience as a Health Visitor
managers not best mentors

Others as memtors
Specialist Health Visitor for Child Protection
Acts in a dual role of mentor and supervision of the Child Protection discuss caseloads
probably twice a year not restricted to Child Protection issues
excellent helpful, setting the objectives things I wanted to know further,

Research methods
theories of research quality and quantities and different types of research
we had to do **a research proposal and a literature search and like that.**
the foundations
could start a small project with help, with more guidance,
subject knowledge for assessment

What was missing
things like public health, special needs more counselling skills

Essential subjects
psychology definitely one of the **most important** things could have **done with more**
Sociology, how people are labelled and how **society views different people**, I think that helped.
professional practice
related to what is different about health visiting
Working to the **principles,** are quite important points of **health visiting.**
social policy,
law in context of child protection and courts
we didn't really do very much at all on ethics.

Appendix 6N - Table 10

Review this file with child records file (health visitors)
Child held records the impact upon
Needs assessment Documentation
HV

Documemtation
Child Held records are specifically for the child
child record just be routine health development.
still keep a **family record**
working specifically with the **mother** I would go in the **family record.**

Scrapping health visitor records
Explicit by the Trust notvery strict about. because of high child protection rates in the city.
Impact of scrapping that Health Visitor documentation of the visit, **any concerns** become **too child focused**
important to look at what's going on in a family
not just the child needs
People are missing out what they are actually doing with a family by not recording it on a **family record.**
Plus the **continuity** if the Health Visitor leaves, caseload
nothing to say about Health Visitorworkwith the mother or another sibling,

we are **accountable** professionals part of the UK Code of Conduct of contuct
client knows the primary visit I take the **child health record** and the parent record
explain that I will be keeping a copy of what I write in the parent record for myself and any letters from hospitals or things
a copy of them for my records.

Impact of Child held records on Assessing families
parent held ones introduced before I started Health Visiting
always want the parent to know what I was writing about them
its important that they see it and they know that its there, that I've written something down,
I would always want to be open with parents about what I am writing about their child.
Most parents are really interested and others just couldn't care less.
because there are bits to do with the child's development
some of them are quite interested and read it and fill it in.Varies

Use by other professionals Auditing Child held records.
auditing use at the moment via questionnaire about who is using it use it, when I use it and the
GPs here are good about it, they will use it.
The CMOs don't use it,Hospital are notorious don't seem to be using it at all.

The principle of the document is not working not at all.

research into their use being undertaken by one of the co-ordinators
managers in information services administration.
I don't know how the documentation has affected my assessment the client

As a School Nurse before
They never used to know what I wrote or saw what was written about them in school nursing,

records **never shared**
now feel they should have known what was being written about the children.

Not found that openness difficult to deal with clients at all

In areas of child protection The dilemma
I worry about it, yes, I worry whether parents are going to react angrily about something \ that I
might say,
but I still feel that its important they know what I'm thinking just **aware of the risk.**
Example in practice
this morning's visit was interesting in terms of a report which was quite clear and honest critical about the mother's parenting skills.
Did you have the same sort of fear when you went in?

Dealing with difficult deisions openess Honesty The fine line

I was worried that she was going to pick up on about development being delayed as being due
to lack of stimulation
we have talked about that before the mother is aware that we are concerned he is not getting enough stimulation
I think she understood why I put about not wanting her to move him ,
I was worried about that that she might think I was being a bit too prescriptive I suppose sort
of thing what she had to do as regards moving.

The preparation process Sharing the decision
It was a very honest accurate report of the state of the children,
it had been talked about at the care team meetings
when ever I go,she is very aware of what I am worried about the Social Worker's worries

Policy here for the mother to attended all of the **care team meetings**
Yes,helps with the **openness**
They are aware right from the minute that you know a care plan is put into place
children being on the register there are regular meetings and she has always been at all of them,
Being discussed openly all the time

Outcomes of openess.
Means I can **focus my work** more without having to beat about the bush about what I am trying to achieve,
The **Mother knows exactly** what I am **aiming** for, what I am worried about and
hopefully it will **give her the confidence to communicate** oh this isn't working, I've got a problem with this
that **we will achieve** what we are **hoping to achieve,** their **parenting** and
the **children's development** to **increase their confidence.**

I'm not sure if it does enhances partnership more with them but tI dont Know why
So dont know if it is a better outcome for the parent or the child?
objectives are much more clearer demonstrated in pratice was very clear of a joint way forward
and I just wondered if you had seen that it actually had an impact.
Not with her but maybe with other families yes.

Example of one individual The visit in the morning
What do you mean not with her?

yes perhaps her own learning disability.
With that Mother I dont know
some things have improved with her
sort of practical things have improved,
but a lot of the time she doesn't always pick up on what we are worrying about,
what I am worried about even though I keep saying to her what it is I am worrying about
she can't always see it.

Appendix 6P1 Category: Concept of need - definitions and perceptions (1) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Need as changeable or static	Needs evolve over time	2,10							
	"Her situation's changed; that was something that came out this morning"		2,5,7 9,12						
	"There's always something that needs to be looked at again, or something's changed"			2					
	.."things which might have developed.."						7		
Need as professionally defined/ objective	"I feel she needs.."	1,16							
	"I'm always looking at things from my point of view"			2					
	"They [different disciplines] have different ways of looking at it"								4
	It's important that a third person..GP,HV, DN or PN..picks up ..identifies						1		
	"I made sure she was aware of"					7			
Need as client defined/ subjective	Needs as personal - individual in best position to identify	6,7, 15							
	"If there's a problem that the patient perceives as a problem.."				1,2				
	"Need is a very individualistic concept; we could be in danger of imposing what we perceive as somebody's need on people"							28	
	"Need..is what they feel as an individual whether it be perceived or actual"								5
	"Recognised need..that's the need they can actually see for themselves. We are addressing their needs,rather than our own. We have got to see it from their eyes"						1		
	"It should include expressed need..it's a subjective opinion"					2,7			
Needs as negotiable - constructed by profs + clients	People often open to advice regarding needs	7							
	Elements of both (objective + subjective). His [client's] perception not necessarilly in line with mine			13					
	"Need..being client centred..from different perspectives"								4
	"..or they actually seek help..from the HV"						1		
Need as context bound	Need will depend on eg input from carers	11							
	"They had to get support in because her daughter's going home.."		2						
	"You can't look at anyone in isolation"				5				
	.."need to place that in context because they could be misinterpreting it"						14, 15		

Appendix 6P1 Concept of need - definitions and perceptions (2) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Need as measurable or nebulous	Can measure eg wounds, dependence level	13							
	"Bartel and Waterlow will be useful once we get used to them"		6						
	"Yes things can be quantified but if you concentrate on that you'd end up with a very uneven assessment".			13					
	Things like incontinence or pressure sores measurable: "You will get a pressure mattress if your Waterlow score is below 14"				14				
	"You know of your hard data and your soft data such as vision, height, weight..things like that we look for"								15
Need as hidden or overt	"People may open up gradually" - may be things you miss at first	15,7							
	"You've got to look at everything else that's going on"		1						
	"It may not be something I point out to the patient"			2					
	"There may be a need that may not be recognised by the parents.. there is every liklihood that they could have slipped through several nets..some things may not have been picked up"						1,7		
Need as complex	"A lot of patients have complex problems"		8						
Need as based on deficits or strengths	Both. Need is sometimes neutral - doesn't imply deficit. "It's negative to be looking at the problems"			15fn					
	"I suppose I'm identifying problems to begin with"		17						
	"There may be a slight deficit in that area"						1		
	Medical/social models look at deficits; nursing models look at strengths								21
Need and educational preparation & guidance	Curriculum covered nursing need of people coming out of hospital and need for residential vs nursing home care	17							
	"I don't think there was a lot of theoretical stuff about needs. More nursing needs. It's not till you actually get to do the job that you realize you're covering all sorts of areas. That's part of supervised practice"		19						
	"That [needs in context] might be highlighted on courses"				5				
	"I can remember saying well what are health needs..it was like a presumption that we all knew what health needs were. But I didn't..I was very lost..it is a vast subject". The input [should be] just to talk and think about the issues because there isn't an answer. We looked at theory but we didn't take it any further than theories. It [Bradshaw's taxonomy] rings a bell but I can't tell you anything about it"							6, 30	

fn = field notes

Appendix 6P1 Concept of need - definitions and perceptions (3) Case study site P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Need and educational preparation & guidance (cont)	"What I have come across is through the Community Care Act and background reading..more experience from reading outside college"								4
	Q:"*Did you remember looking at what need was?*" A: "Yes, vaguely"					1			

Appendix 6P2 Category: Needs assessment - characteristics and purposes (1) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Single event or ongoing process	"Ongoing .. a constant thing, not cut and dried .. carried out every time you go"	2,11 15							
	"It takes 2 or 3 visits..you're always evaluating..continuous, ongoing process"		1,2, 17						
	"It's something I automatically do at each visit..a one-off is totally unacceptable"			2,14					
	"You assess every time you go near them..ongoing"				3,15				
	"I've made my initial assessment then..I go back and reassess"					8			
	"Everything I do is looking at needs"						7		
	"I think what you gain from an individual assessment is very limited"							40	
	"I think constantly you are assessing or reassessing need .. continuous and ongoing .. but it does tend to be a one-off event when undertaken jointly"								1,19
Framework/structure for needs assessment	Not explicit - "in my head". No paperwork yet - being implemented. Highly structured format may prevent listening to the patient, but there is need for minimal guidelines	6,12							
	"You're looking at it and keeping it in your head..I fill in their [social services] core assessment..I like to have a basis to work from [nursing models] but I don't think the forms we've got are ideal..they don't allow for change..I can see advantages and disadvantages [of structure]..I always fill in notes as well..[Specialist assessments] are pretty basic - a bit of a bind - too long - overloading"		2,3,5 6,14						
	"The core assessment [joint health/social] - the balance is too much to the social services..we would like a more balanced nursing form. I think a lot of it could be tick box, yet sometimes it's complicated" Need for "menu" of specialist assessment areas - can choose to specialize in on course.			6,13 16fn					
	Not having a form is like "walking a tightrope without a safety net" Have a framework for pain - can see the logic of having a core document but it wasn't nursing appropriate. There's an argument both ways [structured/unstructured] - "I would rather it's valid than perfectly structured. I'd like to see a combination - I'd like some structure. Do we actually need to fill in the forms? I use the activities of living as a framework				1,7,8 9,13, 14				

fn = field notes

Appendix 6P2 Category: Needs assessment - characteristics and purpose (2) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Framework/structure for needs assessment (cont)	"Assessments for child protection are very detailed. HV assessment would cover a wider range in lesser depth. I don't think documentation actually helps..it is a very basic record of your visit"					13, 14			
	"I don't actually follow a model as such - we could use a checklist but it may be missing the point"						14		
	Primary visit has set agendas and standard states you must discuss certain things. I don't always think it's important to have a set agenda.. early on they are very comfortable, you go in knowing the purpose..it's important to keep those issues in mind. Social workers have a tool							14, 20	
	"We have been given a format which has been developed by the trust..like a checklist. My needs assessment is more structured - better for interagency working"								2,18
Purpose of needs assessment	To keep patients independent, at home..to assess for support to maintain independence	4,19 20							
	To support people at home		1						
	Quality of life for the better			1					
	Aiming for independence				7				
	Very much trying to maintain independence						12		
Dimensions of needs assessment (health, social etc)	Nursing needs assessment for social services..for health and social needs	5,19 20							
	Covers everything..medical, social..looks at the patient as a whole		1,17						
	"I see it in a more clinical, nursing way - physical & psychological & social..multiple needs"			1,2					
	"Anything that's a need I should be assessing - psychological, physical, I will always assess someone fully"				1,8				
	"An assessment from the point of view of the HV service..looks at people in a holistic way, physical, emotional, mental health, social, financial..some of it is looking at physical health, but I look at it holistically"					1			
	"I'm actually going in to identify health need"						2,11		
	"Needs could be medical or social. I don't think all clients' needs fall within a medical model"							22, 23	
	"I'm coming from a health point of view and someone else is coming from a social orientation point of view..it's got to be health and social"								4,22

Appendix 6P2 Category: Needs assessment - dimensions and purposes (3) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Assessors for needs assessment	Best if one [DN] assessor - can deal with whole thing. Don't necessarily need to be DN trained. Varies with professional perspective - nursing view holistic, social services only see immediate problem	15, 17							
	Sister does initial visit		2						
	"You will always have one person who is going to have to tie it all together"			15					
	You obviously need to be an RGN				11				
	"With 2 or more assessors you get a fuller picture and it may be the HV is not appropriate within that situation"								20
Specialist (nursing) assessments	"They're a good pointer - the incontinence one's specific..the diabetic one is new..the over-75..we're trying to develop that"		7						
	"I've been involved with child protection where multidisciplinary assessments are made"					12			
Education and guidance for needs assessment	Not taught as a subject apart from one lesson on Orem. Need for more input on management for needs assessment. Needs assessment mostly learned in placement with CPT. This OK for students with community experience, insufficient for direct entrants. Important to be taught the ideal: "you always have to know the best way to do things". Should be taught in theory and practice. Tutors sometimes out of date on practical side. CPTs should come into college and share. Training was muddled. DN training necessary to carry out "complicated" assessments, not "simple" ones. However, can be unrealistic; as a student you have time to do things properly. In reality it doesn't work like that.	4,18 19, 23, 24, 25							
	The models were the nursing models - we did Roper, Roy and Orem in the course. I don't remember receiving much information. We had speakers in about specific things eg leg ulcers, residential home and social service assessments but need more input on the theory side. The CPTs on the course were very useful but you come here and it's different - you can be prepared for the general idea only. Now I'm in the job I'm looking a lot more at social care..I gained from experience - I've learneed quite a lot since doing the job. There's still a lot of preceptorship needed.		5,6, 11, 19, 20						

Appendix 6P2 Category: Needs assessment - characteristics and purposes (4) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Education and guidance for needs assessment (cont)	"I wasn't prepared for it..it's something from experience. I don't honestly remember doing a great deal about needs assessment apart from nursing models..the nitty gritty of needs assessment was not addressed. The application of theory wasn't covered. Time with the CPT was not enough"			4,5					
	"The college talks about assessment as if you go in and assess and walk out and don't do another for 6 months". Did quite a lot about models of assessing - that was valued. Also trust guidelines define what is urgent in needs assessment - they influence standards. But "it didn't come easily. I had a CPT who was very good - linking theory to practice..only retrospectively do you see how much support you did have". Everyone brought in their documentation and "that was good". There should be more structured group sharing of problems.				3,7,9 17, 19, 20, 21				
	Looked at HV models at college "but I looked at more theoretical articles on nursing". The only information was from the CPT - also had standards from the trust					13, 14			
	"We did do a care study, choosing a model..I suppose that was looking at needs"						12		
	"Standards set out in the trust set out agenda. [College teaching] was a very basic level..we had done Roy and Orem and needed to g further. I don't think it prepared me..only with the CPT. Learned about needs assessment from reading apart from assessment of elderly or hospital discharge under the Community Care Act. Would like some form of formal supervision							15, 16 20 22	
	I felt I was inadequately prepared for needs assessment. It would be useful to have experts from their field of expertise..to link theory to practice. Most things didn't come across in practice. I did have [learning] needs met through trust courses and I have supervision weekly..I think it's important for new practitioners. The trust has a philosophy which guides practice..I think my standards guide my work"								7,8, 13, 16

Appendix 6P3: Category: Individual/family assessment - dimensions and skills (1) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Client and family focus	No reference to family - all discussion implied assessment of individual.	fn							
	"Patient and family - there may be key members of the family you need to support in caring for their relatives. You've always got your eyes open when you're in a home and you look at the solution. We were aware of the the family and need for information from the family as well as the patient..the family are the ones who are tense".		1,9, 11						
	Individual focus..also carers and family:"that's part and parcel of the pressures" and they have their needs. 'you have to rely heavily on other people who know them well. For instance his neice has known him 20 years".			1,7					
	"Initially I assessed her..and got impressions about her husband. The family said 'we can't cope'".				5,11				
	Expressed need assessed on an individual basis.					2			
	"I am looking at the family as a group working together and relating to each other".						2		
	"Individual interactions, one to one with clients..all the things I try to discuss at the new birth visit are relevant for families to know..I loo at clients' needs in detail and the whole family dynamics"							1,14 19	
	"At the end of the day I'm there to promote the health of the individual and family"								5
Technical and prioritizing skills	Wound assessment by measurement. Use of measurement tools eg Bartel, Waterlow. Practical skills eg differentiationg arterial and venous ulcers.	2,5, 13, 25							
	First priority to check drugs, health problems, BP and pulse, urinalysis		14						
	"I go through the physical aspects of care first - help walking, sitting, bathing, dressing, eating, then nursing problems eg pressure sores, medical condition."			7					
	Observation - "just by looking at her" eg skin. Urine testing. Go through comfort, position, constipation, drinking.				4,8				
	I like to address the immediate issues to start off with..is there anything bothering mum?..then we look at the child.						14		
	Deal with issues important to them as a priority then move on to my agenda as second priority. Post natal depression measured with tool							1	

Appendix 6P3 Category: Individual/family assessment - dimensions and skills (2) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Interpersonal skills	Listening and talking during bathing and personal care. Looking beyond the leg ulcer to a holistic assessment - "you find out all sorts of things"..gaining a person's trust and encouraging them to open up. Respect for individual preference.	3,4, 6,7, 13, 15, 25							
	Asking questions.."a lot of things come up when you're just chatting. You need to be a good communicator..to form a relationship..allow them to feel comfortable to disclose information..to adjust to your conversation..you pick up whether they're uncomfortable about you asking questions"		9,10						
	Even though the patient thinks "she's come to give me my injection"..I hope I have looked at other things.."indulging in social chit-chat with patients develops relationships which enables greater insight into needs..they give away even more than they realize just in general conversation". Explaining in non-technical language is important.			3,4, 5					
	Communication is the main skill..tact..understanding of non-verbals..pre-empting without being bossy or patronising..being non-judgemental..talking to carers..directly asking and inviting questions.				3,4,5				
	Just sitting talking to clients..interpersonal skills..not being judgemental, not criticizing.					10			
	Has to be taken carefully so they understand.						1		
	"I listen to what their priorities are and try and hear what is important to them..try and let the client take the lead, developing a relationship, then I introduce issues. You deal with it [patients'anger] better if you have understanding..negotiation skills..listening skills..non-judgemental"							1,2, 3,4, 28, 31	
	Communication, liaison, advocacy..being an effective listener, lobbying..flexibility when people come in with needs.								5,15

Appendix 6P3 Category: Individual/family assessment - dimensions and skills (3) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Nursing judgement and decision making	"Reading between the lines"	7							
	"I suppose I sort of judge what the person needs"		15						
	"Some of it is embraced in general nursing skills, some of it assumes you can make quick judgements" (eg assessments for social services)			8					
	"I think we have to see the wood from the trees much quicker". A lot of it is intuition.				2,4				
	" I play it by ear often. I don't know whether that's right or wrong. I used to think when I was a nurse that nurses need skills of understanding to deal with conflict. I see professional judgement as making an assessment".							3,32	
	Need for decision making skills.								6
Conflicts of interest/ problems	"Sometimes "A" is telling you what "B" thinks and..it's all going round in circles..there are times when you need to get people on their own"		12						
	"You have to marry what you think would improve their general condition with what they feel is necessary. It would be quite difficult to do if I hadn't met him before and didn't know his background, in which case referral to a learning disability nurse might be appropriate"			7,10					
	"I think there's lots of things that we may do, not against the patient's will but we cajole them into it"				2				
	"My CPT's priority was..giving them a lecture about smoking and it was the last thing they wanted to hear..it put up a barrier. I would have to be open and honest even if that caused conflict (eg in child protection).							2,3	
	Wherever you go there will be instances where [client] needs don't marry [with professional views] (eg drug addiction and need for shop lifting)"								5
Education for client/ family needs assessment	"Interpersonal skills are something learned through experience, rather than education". DN training develops skills, especially for assessing need in social and psychological domains. Psychology useful for interpersonal skills.	15, 25							
	"Skills can be learned in college and practice. They [college] talked about theories and practice of counselling and communication but you need to physically go and do it and learn from experience".		11						

Appendix 6P3 Category: Individual/family assessment - dimensions and skills (4) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Education for client/ family needs assessment (cont)	"My nursing skills rely heavily on years' experience - I wonder how newly-qualified nurses manage".			8					
	"Skills learned mainly through watching people dong it well and doing it badly..from joint visits..they may express something in a brilliant way".				3,4				
	"I'm not sure if our education helps us with that [being non-judgemental]..we might have mentioned it but never really addressed it".					10			
	Psychology useful for understanding people, but level of teaching too basic for HV preparation.							4	
	Only when you come into practice - especially supervised practice - do you acquire skills through being involved..need to link theory to practice..need more on decision-making..useful to have joint education in communication skills.								5,6, 17

Appendix 6P4 Category: Collective needs assessment - dimensions and skills (1) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Practice and caseload profiles	Not a feature of DN practice though this should be - to give overview of what you're doing, what need there is and what is available eg for carers, leg ulcer care, continence care.	22							
	"They did a profile of the needs of the actual population of this surgery. I wasn't actually involved".		18						
	"We do have to do a casewide analysis every month - we have to do a pressure sore one and we have just done one on leg ulcers and we have with continence. I compared a few areas in P.. statistically, who died at home with nursing input..was the nearest I could get to it per capita..because I thought I'd looked after an awful lot of syringe drivers and terminally ill people".			18					
	"I haven't done a case load profile..that is something I shall be doing. The trust encourages us to do neighbourhood profiles and practice profiles. It turned out there was a significant number of younger women with babies. There's a high proportion of children with asthma..there's a problem with housing".					1,2, 3,6			
	"Practice profiles are becoming more and more important and as a HV it's part of my role to look at the general health of the population within practices and communities".						2		
	"I see needs assessment as assessing the needs of the clients and the community at large in both individual interactions, one to one with clients, and with profiling exercises. I could profile my caseload..but it's not happening here".							1,9	
	"Needs assessment is about the children on my caseload. I was looking through my caseload and looking out information that had been based on various resources and driving around and going to various areas. The GP practice profile looks at hard data more than the HV profile. The HV profile has used information looking at cervical smears, the number of babies on the caseload etc.								2,10

Appendix 6P4 Category: Collective needs assessment - dimensions and skills (2) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Other levels of profiles.	"I think an area would be more beneficial or per DN team because we work geographically here".		13						
	"You can do needs assessment on an area based on census material and that's broadly ward based"					2			
	"..and beyond that at DHA level, looks actually at the health of the population as well".						2		
	"I know in T... they did a survey of all parents of children in school".							9	
	"Before I even came here I was looking at statistics through enumeration districts and looked at the area deprivation..you need to decide which type of profile you can use"								10
Purpose of collective needs assessment	Need to record aggregated activities on computer to argue for more resources.	10							
	"They [profiles] have only just been published. I haven't read it all..there was a piece on continence assessment that just hit me in the eye..I thought that was district nursing quantified. You aim to provide services to meet the needs of your community ideally".		18, 19						
	"On the computer we've had to pull it [information] out and and make sure we haven't got any written in the community as though they're active when they're not and vice versa".			18					
	"Because I've had to do this paper exercise I've had to come to terms with my cases very quickly, so it's helped me. This RN took it up to Viginia Bottomly..my whole profile..so Viginia's read it and it's not come back bacause it's stuck in Whitehall somewhere. It's gone into a bid to the purchaser for an extra £50,000 per year".				19				
	"What came out of my needs assessment of the area was that there is valuable information contained within HVs' caseloads but which wasn't available. It should reflect the needs of clients themselves and groups who live within small geographical areas..it could be used to better effect amongst a team of HVs and if information could be shared and acted on with social services and amongst the PHCT".					1,2, 3			
	"The DHA, the purchasers, could well be interested to see what is going on at grass roots level, of small localities because this must form part of a large overall picture".						3,4		

Appendix 6P4 Category: Collective needs assessment - dimensions and skills (3) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Purpose of collective needs assessment (cont)	"Following the consultation exercise the public health who funded it are trying to fulfil some of the needs. I think it would give us and the DNs a good overview of what happens. I don't know what I would do with the information. I think I would take it to my nurse manager, who would hopefully take it to the trust. I would probably make the public health department aware. We would have to do a big profiling exercise to prove the need for something like that - hand in hand with marketing".							9,10 11, 35	
	"You get a feel for the community. It's important to look through the caseload because it's there you find perhaps an eye test missed".								10, 14
"Intuitive" profiles	"To be honest I don't know all of them, I don't know everyone, but I know a good majority of them".		5,9						
	"..I know what a week's work is going to be like. I know the imminent problems..and when you're thinking about handover you form a profile.			12					
	"Again, I don't have caseload profile numbers for that but there is a definite need for...I suppose it's largely ad hoc, it's not precise data and if you like it's a subjective opinion".					6,7			
Conflicts/problems in collective needs assessment	"We have to think of the community as a whole, not necessarily just individuals, so it would be unrealistic to expect it always to provide everything everyone needs".			14					
	"You could keep the whole population on..supervisory visits..most people do keep an enormous amount of patients on just in case anything goes wrong".				15				
	[The findings] "were different from what the perceived needs of the profession had been. People don't understand what profiling is..there is a lot of resistance..they felt that even if they did prove a need there would be no obligation for the trust to fund or fulfil the need. There often isn't the time to do community consultation, or do the profiling exercises. I think it would be limited if I did it by myself. They don't go and talk to clients, they just profiled it from notes, which stops the community consultation. I prefer to get everyone in a group because I think that's empowering".						9,10 11, 12, 29		
	"We hoped to do a profile together, because what we are doing is replication and is a waste of energy and time..if we work together then we can make the objectives conclusive".								11

Appendix 6P4 Category: Collective needs assessment - dimensions and skills (4) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Education for collective needs assessment	Did a profile on the course of area of practice - identified inability of people to access surgery because of inadequate bus service..surgery met the need.	22							
	"Part of supervised practice was to do a practice profile, but the guidelines were changed several times..I had to try and identify the needs of the area, which is impossible to do as an individual I think. It made you look at the practice you were working in. I think it would have been a lot more use to do it in a group".		19						
	We did a profile as a project during our supervised practice..they changed the format slightly so we did something different..I felt it was time consuming for the amount you got out of it. The ones we looked at were more HV orientated than DN".			12					
	"I carried out a profile of the area [on the course]. [Intuitive profiles] learned partly through what I've seen, partly what I've come across and partly as the team of 4 HVs sharing an office, what we talk about".					1,7			
	"We had to do a community profile as part of our training. I shall do it very much how I did my community profile during my training. We were given rough guidelines but I referred back to the book by Luker & Orr on health visiting and we all found it very useful. Q; *Was that a valuable experience?* A: Very much so because we felt if that was approved we were going along the right lines, though it would have been helpful to have had it checked during its completion. It was one hour giving us very brief verbal guidelines, then there was peer support".						2,3		
	"The public health role wasn't emphasized [on the course] which I think is essential. I think I only know about profiling from what I've read and..people don't understand what profiling is. I have been in contact with some people who have done a profile exercise in T.... and they have passed on some information. I think you should be responsible for it yourself".							7,11 12	
	"We looked a great deal at the role of the HV moving towards public health. [Learning profiling] through observing other HVs you come across".								7, 15

Appendix 6P5 Category: Working and sharing with clients (1) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Seeking clients' views perspectives and trust	Can learn from clients by talking to them. Needs can be identified by clients themselves.	6, 20							
	"My assessments are based on getting to know the patient over a period of time". Important "to get their side of the story".		1,9						
	"It's very individual. I don't plonk people into little categories. Patients or clients will give different bits of information to different people as to how they perceive them".			1,14					
	"I do believe in looking at what the patient perceives as a problem, not what I perceive as a problem. It could be more upsetting to her to have her lifestyle changed dramatically so I just look at making sure that she doesn't feel that there's any problem".				1,5				
	"I think you work together with people more effectively than you just saying 'this is a need for this area. This is a need for this client'. We are trying to find out what the young women themselves want".					2,4, 5			
	"I think you are going to gain far more if you are open with them [parents]. I feel mums know their children best of all and we should be looking to tell us if there is anything wrong".						13, 14		
	"I don't have the right to judge what people's needs are and I think it's for clients to decide what their own priorities of need are. I think my nursing and HV has to be client centred. I allow them to talk about what's a priority first".							1,3, 14, 28	
	"If I am trying to look at the client and build on strengths...it's just enabling them to enjoy their life".								21
Client advocacy	"If she was adamant that she didn't want it then I wouldn't have given it...I try to put a good case forward, to get what they want really".		10, 14						
	"She [social worker] was very bossy and he [client] just felt that he'd lost all control. I feel very much that we're often the last of the patient advocates. They said she would have to go into a nursing home and it was the one thing she refused to do. I actually supported her".				2,10, 11				
	"I was approached by a 16 year old mum... so we worked together. I would also want them to realize that it was a group for them, not for us".					3,6			

Appendix 6P5 Category: Working and sharing with clients (2) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Conflicts and problems in client led assessment	"I think really it should be client and needs led but it so often is a compromise [in view of resources]. I always go in thinking about how I'm going to meet the need of that patient and what I can actually offer".	12, 14							
	"I don't promise anything I can't...and I won't be going in every time..it makes it a bit difficult".		10						
	"She [patient] will only address those which she sees herself as a need, but I also have to think of her husband...it's a thorny problem. The social services is entirely resource led at the moment...I hope we are more balanced".			10, 13					
	"It should be needs led..I can see in the real world the need for it to be slightly more resource led".				13				
	"If there is concern regarding child protection issues, we do keep a second record, but the parents are aware of it. I think one has to listen to the parents ...but I'm wondering whether they are being absolutely honest with themselves and me or whether there is a certain amount of denial there. I do hear what mum says ..but ...what I could see was a child that was possibly developmentally delayed".						13, 15		
	"I did feel HVs went in with their agendas and the client didn't feel listened to. It's definitely professionally led. We decide what the priorities are..I think a lot of HVs in the profession feel threatened by the parent held records but I don't. I honestly don't think the trust are interested in what clients really want".							2,8, 31, 37	
	"The element of resource and policy driven..prevents me from perhaps giving the total client needs led approach because of resources".								18
Empowerment	"I believe strongly in parent held records. It gives them a responsibility. We are there not to monitor and police people...we are there to help them meet their needs".					9,10			
	"That [parent held records] also empowers the parents because rather than feeling that they have got to ring up every time a problem occurs, they feel they can open it up and their questions may well be answered".						13		
	"Now we are moving over to parent held records and that is where the power should be, because we are talking about self-empowering, encouraging individuals to take responsibility"								2

Appendix 6P5 Category: Working and sharing with clients (3) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Education for client-centred assessment	"I think you can be prepared for the general idea, but when it comes down, you have to look at the individual".		21						
	"One thing that was really missing was the examination of different cultures".					11			
	"I've been on a course...where they said all the child development we do is all very well and good but it's the parents who really know their children best"						14		

Appendix 6P6 Category: Joint/collaborative/interagency working (1) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Advantages of interagency working	Practice includes working with other agencies which may involve GPs, OTs, physios, speech therapists, voluntary agencies, neighbours: "what we can't help them with, maybe someone else can".	1,11 14							
	Involving the social services - "you're getting them in for personal care and actually following up on what happens. They [social services] are happy to accept my assessment. The social services have a meeting on a Tuesday morning...and I try to make a point of going down every week...I find out what they're doing and perhaps understand why they can't put this care in. If we're visiting, we know whether they've got an appointment, so that's usually picked up. So I'll get feedback if I go to their meeting".		3,4, 13						
	"It's not just me, there's the whole primary health care team and other agencies; if I don't consider it's something that a DN can provide, social services have weekly meetings and one of us from the team attends every week, which means we can brief them on anything that needs to be clarified...they do rely on us for extra information...very helpful.			2,8					
	"They have to be closer because otherwise it won't function...we're both interdependent on each other...I can't get her care without social services and social services can't get people into nursing homes without us".				6				
	"The most important thing for me is to understand the roles of the primary health care team and their priorities". Have got to know speech therapists and social workers as individuals and that's helped working relationships.							17	
	"The DN tends to be caring more for the elderly but I'm providing support as a continuity from hospital to home"								16
Referrals and contact between agencies	Practice includes referrals to social services, bringing in other agencies. "I might refer to a GP if we want physio or speech therapy...and voluntary agencies as well".	1,4, 7,14							
	"They [social services] will often ask me if they're concerned about something. I spend quite a lot of time 'phoning and sorting things out and referring them to different people and agencies".		8, 13						
	"I've realized with residential care it is often the most inexperienced people that are delivering the most care and they are the ones you need to speak to, not the managers".			4					

Appendix 6P6 Category: Joint/collaborative/multidisciplinary working (2) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Referral and contact between agencies (cont)	"If there's an unmet need that I don't feel I'm the right person for, then I will refer on and they will have to go in and assess".				15				
	"I have approached people within social services with certain ideas about groups we could set up..I approached a youth development officer and we invited some school nurses and an educational adviser to come along to our meeting".					3			
	We go to the social work department every week to the allocation meeting. Otherwise we speak on the 'phone".						10		
Intra-agency working - the nursing team	More support staff would make role easier. DN qualification not necessarily needed for assessment - D and E grades help and feed back. "I know who I can ask - you get to know your team".	9							
	"The actual staff can go in and do the first visit provided they're followed up by the G grade sister...I trust my staff and if they identify problems they'll come back to me...and I value their opinion as well...some people will relate better to other members of the team. It's working as a team to sort out what we can do to help".		2						
	"We do have a few [learning disability community nurses]. I didn't have a great deal of contact with them but I certainly know how to ring them up and find out if they could give me a hand...the G grade holds the responsibility for assessment and planning. Patients and clients will give different bits of information to different people".			7,14					
	I do feel there isn't a problem in a staff nurse assessing - they would do a safe assessment but maybe not a competent one".				16				

Appendix 6P6 Category: Joint/collaborative/multidisciplinary working (3) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Problems of interagency working	Community care means a takeover of what used to be within the nursing domain (eg personal care) by "young girls and what have you who aren't qualified even though the nurse still has input into the package". Can be difficulty working in "grey areas" eg supply of hoists. "Social services may see things totally differently to the way I see it". Sometimes there is doubt as to the skills of care co-ordinators - not really sure what they do. Can't make care co-ordinators see a patient needs help twice a day - "we do have battles".	3,9, 11, 15, 16							
	"Our experience to date is that anything I write will merely be a suggestion and that the need will be assessed on financial grounds rather than other grounds".			4					
	"I'd be irritated if I washed someone and someone else was going in half an hour later and washed them again, that's a waste of my time. That doesn't happen any more. The social worker in the hospital started ringing up - they took it personally we wouldn't take this lady home".				10, 11				
	"I believe there is an overlap between people who work for social services, particularly with the under 8s, and HVs. I think we do duplicate the work and could work together a bit more. I see health as backing into a corner and social services attempting to expand and spread".					2			
	Ideally we should be liaising with all the primary health care team and others but it doesn't happen in reality - largely due to separate bases and GPs who don't understand the role of HVs. Don't have any experience of joint assessment and not familiar with social service documentation.						8,9		
	"I think we work very independently", though in child protection work closely with social worker - but difficult to track them down.							18	
	"What we are doing here is replication and it's a waste of energy and time"								11

Appendix 6P6 Category: Joint/collaborative/multidisciplinary working (4) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Education for collaborative working	Joint training for community care through the trust exists, but is not really helpful - rather muddled. Covered assessment and referrals.	17							
	"They [social services] came in briefly on the course. In our clinical areas I think most of us did try and go and spend a day with the local social services...we arranged that ourselves".			9					
	Learning with HVs "useful for understanding. There was lots of good things but it meant we had a lot of time on children. I know a lot of our patients hold records and things like that but I feel probably with only a little bit more we could have been HVs, but I've no desire to be a HV".				20				
	Can't remember anything about joint assessment in college course.					12			
	Interdisciplinary learning important - to appreciate how other disciplines saw their role and how HV and DN roles overlap.						17		
	Didn't learn about multiagency assessment on HV course - felt completely unprepared to deal with child protection - need formal supervision. Recently did a child protection course which involved multidisciplinary group - police, probation officers, education - helpful.							19, 27	
	There were some elements of joint teaching but few - not with social workers which would have helped. "I have done child protection level I and found the multidisciplinary approach an eye opener" - insight into other professionas eg police. Look forward to doing level II.								17

Appendix 6P7 Category: Knowledge and provision of service response (1) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Accessing services and resources	A good system exists in case study site for loans and referral to agencies. The trust has a special needs fund. Profiles can identify resources.	8,9, 22							
	If asking for aids and equipment, will do a social services core assessment - this will go straight to the OT. "If we put a referral through suggesting a home visit then they usually pick it up...they do let us have chiropody and things like that...they're usually quite good".		2,13						
	"We couldn't fit a hoist in the room so I blocked the discharge".			10					
	"There was a whole funding issue, so we are looking at the different ways of possibly getting funding for that...I'm going to have to look at special grants and schemes and maybe even charitable funds".					4			
	"I know there is a vacant community hall down the road...that's a starting point, developing something to fulfil unmet need".							29	
	"We talked about contacting various MPs and city councillors to push forward...to use influence"								1
Links between assessment and provision	"It's [ie assessment] actually linked to service provision...ideally it would be great to have it separate from provision".		16						
	"I would hope I would identify other areas or other agencies that could input into areas".			2					
	"It doesn't necessarily mean I can sort it out...if there's a need I should know where to go or who to ask for help. I always know who I could ask. I don't understand how you can always separate provision and assessment...because I assess and I provide. It's more time effficient".				1,10, 14, 15				
	Assessment must be linked to service response "so that the appropriate provision can be made...if there are gaps in certain areas then provision can be focussed on those gaps".						5		
	"I think it has got to be the role of the HV that he or she is aware of what resources are and if you don't then you go and find someone who does. I think it [assessment] needs to be linked to service provision because at the end of the day you are using needs assessment to, if you like, allocate service provision".								11, 19

Appendix 6P7 Category: Knowledge and provision of service responses (2) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Ethical issues	"It all boils down to finance and resources. You have to look at the resources because you know if the resources aren't there then you can't supply them. You have to meet it half way sometimes. You have to be realistic".	3,12							
	"Social service are experiencing financial problems...they're forever looking to see who has the most need and who can do without, so that's quite difficult, because you can refer someone and it'll be bounced right back. When I speak to her [social worker] about the assessment I rather suspect it will be something over which I have no control. I think you always have at the back of your mind how much you can give in terms of manpower...you are talking about rationing, we all do that...because there's only a certain amount of time in a given week, given the resources. Having said that, I don't think we stint where it's needed...I'm thinking of our terminally ill patients. We're never going to have an endless budget, so it will always be linked in some way to resources".			8,10 11, 14					
	If resources are unable to meet needs "that's quite an ethical issue...I just apologise and say I'm sorry there is no playgroup subsidy...just seeing people who are obviously in need but there aren't the resources there to fulfil that need".							28, 29	
	"The element of resources and policy driven prevents me from perhaps giving the total needs led approach.								18
Education for service provision	"Service provision is different in every area. So you learn this in practice...it's difficult to incorporate into a course as you can't guarantee people will be able to get what is theoretically available".	8							
	"I've learned a lot since I've been here. Still don't think I know every in and out of what goes on. Sometimes I'll come back and I'll ask how do I get hold of so-and-so or is there such a service. Then sometimes it's just a case of picking up the 'phone and trying to find out what the service is and where I can get it from. I still go away and start finding about mattresses and alternatives".		12, 13, 15						
	"The CPT can only really teach you what she knows, and if she's only worked in one area...that's a shame"				20				

Appendix 6P7 Category: Knowledge and provision of service responses (3) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Education for service provision (cont)	"It was quite interesting talking to other members [on the course] that were working in other areas to find out what services were available to them. And also my alternative practice, that was quite an eye opener. I think it would be good to have an overview of the kind of services that were available nationwide...if I hadn't had the kind of alternative experience that I did, I wouldn't have learned what potentially could be available, and therefore you would never aspire to provide or campaign to provide those kind of services for your clients. I think it would have to be from college,looking at what is available nationally".							33	
	"As you go about the daily work and visit different places I come across new services for example the parent-toddler group that I didn't know of today".								12

Appendix 6P8 Category: Community Care Act and political issues (1) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Impact of Community Care Act - structural and philosophical	"I think involving the social services you're getting them in for personal care...that's probably changed. The government's quite keen to separate the assessment from the provision. The trust has a philosophy...that care has got to be ever changing to meet the provision".		3,5, 17						
	"With the new Act...that immediately brought in our work with social services. I think we're extremely aware now of the need to work with social services and other agencies in a way we hadn't done in the past. When the Community Care Act came in, a form was devised in conjunction with social services for us all to use [for assessment] but we found really with experience that social services still use it, but they don't use the ones that we've filled out".			1,4, 5					
	Definitely made a difference to needs assessment: "everyone's looking at needs...I mean the word "needs" wasn't really known, you were looking for problems."				6				
	"It affects people in the mental health area. GP fundholding is connected with it".					12			
	"Transferring care from the acute sector, moving out into the primary care sector, whether it's psychiatric or general care, and into people's homes, or nursing homes, residential homes, or community groups....so we should be looking at the needs of carers...people who live within a community would fall into our role as well".						7		
	The emphasis for care would be out of institutions and into the community and that basically means a house, family home or in the client's home. Also within the Act was the development of trusts and a market led kind of business approach to the NHS which has lots of implications. I know that people were assigned a care manager and it's their responsibility to gain information about an individual".							21, 22	
	"We are moving into an era where we are moving away from institutions into perhaps more privatization...the idea of more voluntary services taking more responsibility".								12

Appendix 6P8 Category: Community Care Act and political issues (2) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Political issues - resoure and ethical implications	There are concerns regarding the effect of community care on the quality of care patients are getting as care is referred on (outside nurse's remit). Had to raise money from charity for equipment since excluded from special needs fund and GP (fundholder) budget. "That's not part of my job" - detracts from work of assessing. Grade of nurse employed is dictated by resources. Need for more money in community care and for change of government - "you do get political".	3,9, 16, 23							
	"If we're trying to do a joint care package we're quite bound by the social service budget".		13						
	"I don't want to raise people's hopes and then discover that that's not the way it's going to...we're never going to have an endless budget".			11, 14					
	"That took hours and hours of time...we were whizzing around seeing other people because we were so busy. If the care package that you're putting in together is more expensive than a nursing home, they have to go in, even though that's not what the patient wants. If there's only a finite amount it should be spread around and not given to one person".				11, 12, 13				
	"If you ask people to look at what their needs are that raises their expectations that their needs may be met and it causes dissatisfaction when the needs aren't met...that causes me a problem...they [clients] receive it on a very political level. Luckily...I haven't usually experienced anger aimed personally at me. I think they [the trust] are interested in providing what has historically always been provided...in the most economic way they can...to provide something the client wants may be expensive. And in a way the government are responsible for that. There hasn't been the funding to provide care for those extra people they discharge".							29, 37	
	"Where will they get funding? Deficits and problems are directly related to resources. It's basic economics isn't it? ...a different ethos put on to society".								12, 21

Appendix 6P8 Category: Community Care Act and political issues (3) Case study site: P

Theme	Data examples	DN1 page	DN2 page	DN3 page	DN4 page	HV1 page	HV2 page	HV3 page	HV4 page
Education for community care.	Didn't do much on community care on course. Did an essay on the Community Care Act "which we researched ourselves" but can't remember lecture about community care. Not prepared for difficulties in accessing resources..."when you come off the course you think you're going to sit there and do the G grade role".	3,9, 18							
	"It was skirting the issues of discussing the NHS and Community Care Act and the ideals of people being assessed for need".		19						
	"We actually did a project or an essay related to community care - it seemed to come up in virtually every other module...in fact I think we all got to the point where we thought if we get this again we'll...I felt it had a bit of overkill".			3					
	It [Community Care Act] was something that we had repetitively done again at the same level...you were critical of it and we had debates and then we had someone in and talked about it and then we'd do a literature review on it...but there was no idea as to how anybody could make it work better. We weren't allowed to focus on examples, everything had to be from journals".				5,6				
	Learning about the Community Care Act was from "the nursing press, the national press and during my time as a staff nurse in a hospital. We had to do work related to the Community Care Act [on the course]...there were debates and lectures/discussions...we could actually have done a written piece of work on the Community Care Act as such".					11			
	"I guess it would have come up somewhere in my first year when we were looking at care in the community".						7		
	" There is a lot of marketing because you see a few bits in the local newspapers". On the course looked at the Community Care Act.								13

APPENDIX 7

PHASE THREE: NOVEMBER 1995 - JANUARY 1996
THE EXPERT PANEL

The panel of experts from the various interest groups invited to critically examine and comment on the findings and preliminary recommendations.
The panel was also be asked to consider:

- the extent to which the proposed educational approach seemed likely to meet the requirement of the intersectoral collaboration, quality assurance and consumer satisfaction
- the consequent implications for the ENB and the future provision of education for community nurses relating to needs assessment.
- the suggested time to review the findings and interim 'implications'/recommentations for future education programmes and for the ENB

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QUALITY EDUCATION FOR QUALITY CARE
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HIGHLIGHTS

TWENTY THREE

NOVEMBER 1996

An Investigation into the Changing Educational Needs of Community Nurses with regard to Needs Assessment and Quality of Care in the context of the NHS and Community Care Act, 1990

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Mr. Richard Ryland, Quality Assurance Director, East Sussex Health Authority

Abstract

This project set out to examine the changing educational needs of community nurses with regard to needs assessment and quality of care in the context of the NHS and Community Care Act, 1990. The study was divided into three phases. Phase one set out to explore and clarify what is meant by 'needs assessment' through a series of focus group discussions. These data were analysed, and used to develop an observational instrument and interview guide for phase two. Phase two used a multiple case study design to examine the educational preparation and the practice of needs assessment by district nurses and health visitors, and develop recommendations for future educational provision. Before these were finalised, in phase three the findings and early proposals for these recommendations were scrutinised by a group of 'experts' from the various interest groups; their deliberations were subject to a content analysis and incorporated into the final report. The methods used are outlined under the separate phases, and key findings incorporated under the overall conclusions of the study.

Background to study

This two year study was planned in the summer of 1993. It was acknowledged that the ability to carry out a full assessment of the needs of individuals, families and communities has always held a central place in the practice of community nursing (CETHV 1977, Luker and Orr 1992). As well, the skills of community nurses in assessing needs are integral to the requirements of both the Children Act, 1989 and the NHS and Community Care Act, 1990 but this legislation changed the emphasis, and perhaps the nature, of practice, with consequent implications for the educational preparation of practitioners. Moreover, the linking of explicit roles, rights and responsibilities with 'needs assessment' focused attention on the variable meanings attached to the term. Educationalists need information for planning courses of preparation which meet the new requirements and which take into account these potentially disparate viewpoints.

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Phase One

Phase one aimed to elicit views and clarify meanings attached to the notion of 'needs assessment' in the context of community nursing, and to set the scene for subsequent phases of the study: details are reported elsewhere (Cowley et al 1996). A series of eight focus group discussions were held with a total of 91 participants, drawn from a variety of 'interest groups' expected to have relevant opinions on the subject.

Analysis of these data revealed that the term 'need' signifies a dual concept:

- it is personal, variable, subjective, dynamic and immensely changeable according to context,
- it is capable of precise specification and sometimes measurement, at least to a degree.

While these elements may appear contradictory, the testimony of the focus group informants suggested that any assessment would be incomplete unless it encompassed both the aspects. Needs assessment should be purposeful and is thus linked to a service response. There is another proactive aspect of needs assessment, which is the service planning element. Without this essential element, services and assessments risk becoming entirely reactive and eventually incapable of true responsiveness.

Thus, 'need assessment' appears as a tripartite venture which involves

- recognition of needs,
- assessment of needs,
- linking the assessment of needs into the on-going process of service planning.

Each aspect requires specific, but closely interdependent knowledge, attitudes and skills which community practitioners need to acquire during courses preparing them for qualification.

Phase Two

Phase two adopted a multiple case study design (Yin 1994) based in each of four different Regions. Each 'case' or unit of enquiry comprised the educational programme provided by one college, and indications of its impact as demonstrated in assessment practices and nurse perceptions in one Region.

The findings from phase one were used as a basis for developing a structured observation schedule and semi-structured interview guide. Recently qualified practitioners (health visitors and district nurses) were observed during a regular shift ($n=134$ visits), concentrating on their practice of assessing needs, and on liaison and collaboration within teams and across sectors. They were interviewed after the observation period ($n=32$ practitioners), to determine the extent of formality they attached to each assessment, and elicit information about aspects which may be embedded in everyday practice as well as those recorded for explicit requirements.

The analytic strategy addressed the research aims through single and multiple case analyses across the four cases, using an iterative process of pattern-matching, replication logic and explanation building (Yin 1994). The preliminary analysis yielded two broad themes which informed further analysis.

1 A descriptive 'taxonomy' as a basis for classifying the variants of needs assessment was elicited; this could be used to help clarify the whole phenomenon.

This illustrated the various aspects of needs assessment demonstrated in practice. When applied further to the data, the taxonomy revealed the complex interactions within needs assessment between:

- the different ideals (relating to policy, nursing and ascribed worth),
- the various types (purpose, formality/specificity and complexity)
- and timing (in relation to client, service and practice issues).

2 Various points at which a 'strategy-practice' gap seemed likely to arise between policy and practice were identified:

- as 'ideals' are translated into policy, such as the NHS and Community Care Act 1990;
- as these policies are translated into local planning for services and educational curricula;
- as these plans, subsequently, are turned into service provision and into teaching;
- the cumulative impact of these three elements can be demonstrated in the reality of practice. This final point represents an accumulation of potential gaps arising in service provision, educational preparation and practice.

Where a gap occurs between what is expected or hoped for and what actually happens, this adversely affects perceived quality of a service (Parasuraman et al 1985). The cross-case analysis indicated that such a gap might arise at any of the points highlighted above. It showed that any 'strategy-practice gaps' in the service field may be widened further by an associated 'theory-practice gap' during the educational process, or reduced by the development of high level specialist practice skills during the preparation period.

Drawing on these findings, preliminary conclusions were drawn regarding educational provision relating to needs assessment in the different areas, and how this is translated into practice. Tentative recommendations were developed about how community nursing programmes should deal with the issue of needs assessment, and taken forward (with the findings) to phase three of the study.

Phase Three

A panel of 'experts' from the various different interest groups were invited to critically examine and comment on the preliminary recommendations, particularly considering their feasibility and utility. A content analysis of their responses allowed the analysis of data drawn from the specific needs assessment practices of health visitors and district nurses to be placed in the wider educational and health policy fields, before the conclusions were finalised.

Overall Conclusions

The accumulated results from the whole study gave

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rise to certain implications to be considered by the English National Board; these are summarised and explained with relevant findings below.

1 *Issues relating to needs assessment and community nursing*

1.1 The ability to assess needs of individuals, families and the local population served on the community nursing caseload appeared as a holistic endeavour; in practice these different aspects were not fully separable from each other, or the rest of community nursing work. Thus, needs assessment skills appear central to all community nursing, so their acquisition is intimately linked to the development of specialist community health care nursing ability.

1.2 Certain aspects of needs assessment were learned better than others, perhaps due to a lack of clarity and understanding about some of the embedded features of need. Therefore, the particular skills and knowledge required for needs assessment require highlighting, to aid clarity and the learning process. Interpersonal and communication skills necessary to elicit variable and individual perceptions of need were generally afforded more attention in curricula than the specific measures required to undertake formal and structured assessments; both aspects are equally important. Students also need to understand the different ideals which underpin needs assessment according to their basis in holistic nursing or policy-driven perspectives, the various types of needs assessment and the way the timing of assessments vary according to different clients' practice and service requirements.

1.3 Specialist community health care nurses are required to accept a high level of professional responsibility for influencing factors which have an impact on their practice, as well as continuing to develop their own knowledge base in relation to new developments. The availability of post-qualifying support and preceptorship periods appeared very variable, so the student must have developed this capacity prior to completion of their courses. Particular attention is needed to the transition from student to qualified specialist, and to ensuring that practitioners are able to work independently by the time they qualify.

2 *Issues relating to needs assessment and joint working*

2.1 The principles of needs assessment (as in point 1.2) should be taught as part of the common core between all community nurses, and some aspects of this learning might beneficially be shared with students from other disciplines, such as trainee general practitioners and student social workers.

2.2 There remains a particular base of knowledge to underpin assessments made within the different areas of community nursing practice, and extra attention should be given to these within the specialist modules. For instance, health visitor knowledge appeared more strongly linked to child development, nutrition and health promotion, while district nurses made greater use of theory related to pathology, pharmacology and physiology. The data hinted that self-confidence in one's own professional knowledge base, and respect for that knowledge from colleagues, assisted interprofessional working.

3 *Issues relating to needs assessment and professional judgement*

3.1 The data demonstrated that, when assessing needs, practitioners were often faced with practical and ethical dilemmas involving different priorities and perceptions within families, between formal agencies and their clients/users, and in dealing with interdisciplinary working and resource allocation issues. Thus, community nurses need a deeply ethical and practical wisdom (*phronesis*: Carr 1995), the ability to incorporate theoretical perspectives into everyday thinking (*praxis*: Carr 1995) and to integrate finely judged decisions into practice. Learning about ethics as a separate academic exercise is considered unhelpful in achieving this depth in professional education (Moline 1986). Instead, developing the high-level skills required for the full spectrum of needs assessment should be centred around developing the overall capacity of the practitioner to exercise professional judgement in dealing with such intricate situations.

3.2 Professional judgement requires the development of critical skills, ability to conceptualise and articulate practice. A number of participants in this study appeared to find difficulty in articulating abstract concepts, and were thus disadvantaged in their ability to grapple with the sometimes conflicting and complex situations they faced. Education should continue to be minimally at level three (degree level) and consideration should be given to extending opportunities for post-graduate qualifying courses (masters level).

3.3 Lecturers should be encouraged to engage in 'practical discourse' (Fish 1995) with their students in college, to facilitate the development of critical ability and the ethical, moral and practical basis for professional judgement. This could take the form of students rehearsing and questioning in college the inevitable tensions and constraints of different requirements in the practice situation. This teaching should be acknowledged as contributing to both theory and practice.

3.4 Central to the quality of learning through practice is the opportunity to observe an expert role model and teacher in a variety of learning situations, who should subsequently be able to reflectively discuss, coach and debrief the student following her own practice in needs assessment (Fish et al 1991, Schon 1983). The important role of the caseload holding specialist teacher in the practice setting (community practice teacher) was highlighted in the data.

3.5 The development of professional judgement requires the opportunity to acquire a sufficiently wide repertoire of experience in different needs

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Further information

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assessment situations. However, a number of practitioners found it difficult to gain sufficient experience during their educational preparation. This, and point 3.4, raised two separate but linked issues which should be the subject of serious consideration by educational consortia:

a) the length of time spent in the practice situation, and the quality and range of needs assessment experience available, and

b) the availability and quality of community practice teaching time.

If suitable needs assessment experience and/or availability of community practice teaching time is limited, the length of qualifying courses may need to be extended.

4 *Issues relating to teachers of needs assessment in community nursing*

4.1 Study data in this research did not allow for comment on the effectiveness of current knowledge of educationalists. However, it did suggest real difficulties in teaching in an uncertain and rapidly changing environment in community nursing education and practice, which warrant further exploration. Consideration should be given to a formal research investigation of the continuing development needs of educationalists teaching on specialist community nursing courses.

4.2 There was some concern about the extent to which lecturers were able to facilitate learning about the practicalities of working in the 'new NHS', when they had, perhaps, not held community nursing caseloads themselves since the NHS and Community Care Act was passed. Holding a caseload is not generally feasible for lecturers, nor is occasional, highly circumscribed and part-time contact with individual clients necessarily appropriate for maintaining specialist skills. They might be encouraged to engage in consultancy work and in research activities which take them into the field of community nursing as an alternative means of maintaining practice credibility.

4.3 Given the centrality of their teaching role, the level of preparation for community practice teachers may need to be upgraded. Consideration should be given to a post-graduate qualification, since it is considered important for them to have a more advanced level of preparation than the undergraduates they are helping to prepare. The programme should also enable practice teachers to facilitate the high level of reflective learning described at 3.4 (Fish et al 1991, Schon 1983).

Details about the project

This project was commissioned by the English National Board for Nursing Midwifery and Health Visiting in the autumn of 1993. The project ran from January 1994 – December 1995; it examined the changing educational needs of community nurses with regard to needs assessment and quality of care in the context of the NHS and Community Care Act, 1990. The study clarified the nature of need and needs assessment by community nurses. It drew attention to the complexity of the specialist skills required, and suggested ways that these may be developed through programmes of professional education. The overall conclusions and study findings will be of particular interest to educators and practitioners of community nursing, their managers and commissioners of community nursing education. It will also be of interest to those involved in needs assessment in other fields, to purchasers and providers of health care in all settings and to students of social and health policy.

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